**GREAT NORTH MEDICAL GROUP**

**COMPLAINT FORM**

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| **Complainant’s Details** | |
| **Name** | **Date of Birth** |
| **Address** | **Tel. No.** |
| **Patient’s Details (where different from above)** | |
| **Name** | **Date of Birth** |
| **Address** | **Tel. No.** |
| **Details of Complaint (including date(s) of events and persons involved)** | |
| **Complainant’s signature** | **Date** |

|  |  |
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| **(if the complainant is not the patient)** | |
| **I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorise the complaint set out overleaf to be made on my behalf by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **And I agree that the practice may disclose information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (only in so far as is necessary to answer the complaint) confidential information about me which I provided to them.** | |
| **Patient’s signature** | **Date** |