**GREAT NORTH MEDICAL GROUP**

**COMPLAINT FORM**

|  |
| --- |
| **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** |

|  |
| --- |
| **(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** |