HEDINGHAM MEDICAL CENTRE

COMPLIMENTS, COMMENTS, CONCERNS & COMPLAINTS FORM

Your details	
Name	
Address	
Contact Tel No.	

Patient's details (if different from above)

Name	
Address	
Date of Birth	

Full details of complaint	
Date	
Time	
Identify members of practice	

Full description of events (i.e. the facts and surrounding circumstances giving rise to your complaint)

continued over

continued from p1

Complainants signature	
Date	
Where the complainant is NOT the patient - please complete and sign at 1 or 2 below -	
1. I ……………………………………………………….hereby authorise the above complaint to be made and I agree that members of the practice staff may disclose (in so far only as it is necessary to do so to answer the complaint) confidential information about me which I provided them.	
Patient's Signature	
Date	
2. I ……………………………………………………….hereby authorise the above complaint to be made and I agree that members of the practice staff may disclose (in so far only as it is necessary to do so to answer the complaint) confidential information about (patient's name) …………………………………….	
Patient's Signature	
Date	
Relationship to complainant	
Relationship to patient	

Please return this form to the Surgery for our prompt attention