



Helix Medical Centre

Herts & Essex Hospital, Cavell Drive, Haymeads Lane
Bishops Stortford, Hertfordshire, CM23 5JH.
Tel: 01279 594450

THIRD PARTY COMPLAINT FORM

Please complete this form along with our Patient Complaint Form, this will ensure we have your authorisation to investigate a complaint and liaise with your representative.

SECTION 1: PATIENT DETAILS

Patients Name:	
D.O.B. / NHS No	
Address:	
Contact Details:	Tel: Email:

SECTION 2: THIRD PARTY DETAILS

Third Party Name:	
D.O.B.	
Address:	
Contact Details:	Tel: Email:

SECTION 3: DECLARATION

Declaration:	<p>I hereby authorise the individual detailed in Section 2 to act on my behalf in making this complaint and to receive such information as may be considered relevant to the complaint. I understand that any information given about me is limited to that which is relevant to the subsequent investigation of the complaint and may only be disclosed to those people who have consented to act on my behalf.</p> <p>This authority is for an indefinite period / for a limited period only*. (*Delete as necessary - choose one option)</p> <p>Where a limited period applies, this authority is valid until/...../..... (insert date)</p>
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SECTION 4: SIGNATURE

Date:
Patients Name & signature:

Office Use Only (Reception to review & forward to Complaints Management)

Date Received:	Received By:	Passed To:
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