MEDICUS HEALTH PARTNERS

Please complete the details below and send to the practice email or post a copy for the attention of the Practice Manager.

If the complaint is on behalf of someone else, please complete the consent form and submit with this information, we are unable to release information or discuss details without consent.

Today's Date	
Date relating to the complaint if different	
Your name	
Contact Number	
Email Address	
Your Address and Postcode	
Date of Birth	
Medicus Health Partners - Branch Name	

Please insert Complaint details: (Include dates, times, and names of practice personnel, if known)

Signature	
Please Print Your Name	

MEDICUS HEALTH PARTNERS

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

ENQUIRER / COMPLAINANT NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

_____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW.

I fully consent to my Doctor releasing information to and discussing my care and medical records with the person named above in relation to this complaint only, and I wish this person to complain on my behalf.

This authority is for an indefinite period / for a limited period only (delete as appropriate) Where a limited period applies, this authority is valid until _____ (insert date)

Signed (Patient only)

Date: _____