CONSENT TO SHARE INFORMATION WITH A REPRESENTATIVE ABOUT YOUR COMPLAINT

I authorise HIGHFIELD SURGERY, in relation to complaint reference number _____, to share and discuss with the representative named below any confidential personal and medical information that is relevant and necessary to investigate and resolve this complaint.

To be completed by the Patient.

I understand that this consent will remain in place until the complaint has been resolved. If I wish to withdraw consent at any time, I will contact the surgery to let them know.

Full name	
Date of birth	
Address & postcode	
Contact number	
Patient signature	
Date of completion	

Please supply the details of the representative you wish to speak on your behalf with regard to the complaint

Full name	
Date of birth	
Address & postcode	
Contact number	
Email address	
Date of completion	

Please note: Your representative will only be given access to information from your medical record that is considered relevant to this complaint. This may include sensitive health information. By giving your consent, you understand that your representative may receive correspondence from the surgery that includes or refers to this information.