Rathfarnham
Medical
Centre

FEEDBACK FORM

Patients full name .....

Date of Birth.....

Address.....
....

Post Code..... Telephone Number.....

GMS Number..... Complaint/feedback details: (Include dates, times and names of personnel, if
known) .....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
....
.... (Continue Overleaf if necessary)

Rathfarnham
Medical
Centre

FEEDBACK FORM – PATIENT THIRD PARTY CONSENT

Patients full name .....Date of Birth.....

Address.....
....
Post Code..... Telephone Number.....

Enquirer/ Complainants Full name .....
Relationship to Patient .....
Address .....
.....Post Code.....
Telephone Number .....

IF YOU ARE COMPLAINING OR GIVING FEEDBACK 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: .....