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**T o n g M e d i c a l P r a c t i c e**

**COMPLAINTS FORM**

**Your Details**

**Name:**..................................................................**Date of Birth:**...................................................

**Address:**.......................................................................................................................................

.................................................................................**Post Code**......................................................

**Home Telephone:**........................................... **Mobile Telephone:**...................................................

**Patient Details (if different from above)**

**Name:**..................................................................**Date of Birth:**...................................................

**Address:**.......................................................................................................................................

.................................................................................**Post Code:**.....................................................

**Home Telephone:**........................................... **Mobile Telephone:**...................................................

**Details of Complaint (including date(s) of events and persons involved)**

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**Complainants Signiture:** ..............................................................**Date:**.........................................

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**THIRD PARTY CONSENT FORM**

**Where the complainant is not the patient:**

I ............................................ authorise the complaint set out overleaf made on my behalf by ............................................... and i agree that the practice may disclose to that person/organisation confidential information about me regarding the complaint.

Date: ...............................................................................

Name ...............................................................................

Date of Birth: ...............................................................................

Address: ...............................................................................

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Patients Signiture: ...............................................................................

\*Please note the practice may contact you directly to confirm this authorisation