# Stoneham Lane Surgery

City Gateway, Parkville Road, Southampton SO16 2JA

**PATIENT CONSENT FORM TO RELEASE INFORMATION TO THIRD-PARTY**

Enquirer / Complainant Full name: …………………………………………………………………...

Home Telephone Number: ……………………………Mobile No:…………………………………..….

Address: ……………………………………………………………………………………….……

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Patient Full Name: ……………………………………Patient Date of Birth:…………………………..…

Patients Home Address: ……………………………………………………………………………...

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Enquirer / Complainants Relationship to Patient: …………………………..……………………..……

**IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT / ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT, THE PATIENT'S CONSENT IS REQUIRED.**

**PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW AND RETURN THIS FORM TO THE PRACTICE MANAGER, WHO WILL CONTACT THE PATIENT TO VALIDATE & CONFIRM SITUATION**

I …………………………………………………………......(insert patient's full name) fully consent to

Doctor…………………………………………………………...…(insert GP Name) to release medical

Information and discuss my care and medical records with the complainant as named above.

This authority is for an indefinite period **OR** for a limited period* only (delete as appropriate)

* Where a limited period applies, this authority is valid until……………………………..….. (Insert date)

Signed ………………………………………………… (Patient)

Print Full Name: …………………………………………………(Patient)

Date: …………………………………………………