Consent Form

Chew Medical Practice has received a complaint from someone other than yourself about your experience of using our services. We will not disclose any information about your medical care to anyone else without your permission. Please tell us by filling in this form whether or not you are happy for us to pass on information about your medical care to the person who has made this complaint.

Your name……

Your address……

I give permission for Chew Medical Practice's response to the complaint made by

…….. (name of person making the complaint)

- to be sent to the person who has made the complaint
- to be sent to the person who has made the complaint and copied to me
- to be sent to me only

  (Please choose one of these options)

Reason for complaint……

……

Signature: …… (patient)

Print Name: …… Date: ……