**Consent Form**

This form is for you to gain consent to progress an NHS complaint on behalf of your friend, partner or relative as their representative. Ensure that you include a copy of this form when making a complaint.

**Section 1: The Representative’s details**

|  |  |
| --- | --- |
| Title (Mr, Mrs, Ms etc): |  |
| Full name: |  |
| Address: |  |
| Postcode: |  |
| Telephone number: |  |
| Email address: |  |

|  |  |
| --- | --- |
| Your relationship to the patient: |  |

**Section 2: The Patient’s details**

|  |  |
| --- | --- |
| Title (Mr, Mrs, Ms etc): |  |
| Full name: |  |
| Address: |  |
| Postcode: |  |
| Telephone number: |  |
| Email address: |  |

**Section 3: The Complaint**

|  |  |
| --- | --- |
| Brief summary of the complaint: |  |

**Section 4: Consent**

Please complete the applicable box below:

(a) If the patient **is able** to consent to the complaint being progressed by you as a representative:

|  |
| --- |
| I am the patient  I agree that the person named in this form can make the complaint on my behalf. I agree they may see my medical records and any other information that might be relevant to this complaint.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

(b) If the patient is **not able** to consent to the complaint being progressed by you as a representative:

|  |  |
| --- | --- |
| I am the patient’s representative  The patient is not able to give their direct permission because:   |  | | --- | |  |   **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

(c) If the patient has died, their next of kin or legal representative must fill this in:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Full name:** |  | | **Relationship to patient** (e.g. next of kin, legal representative)**:** |  |   I give my permission for the Representative (named above in Section 1) to make the complaint on behalf of the Patient (named above in Section 2). I also agree that the representative may be shown any medical records which are relevant to this complaint. I confirm that I have the legal authority to give this permission.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

(d) If the patient is under 16 years old, their parent or guardian must fill this in:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Full name:** |  | | **Relationship to patient:** |  |   I give my permission for the Representative (named above in Section 1) to make the complaint on behalf of the Patient (named above in Section 2). I also agree that the representative may be shown any medical records which are relevant to this complaint. I confirm that I have the legal authority to give this permission.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |