



Athens Way, Lees, Oldham, OL4 3BP

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CONSENT FORM (For Third Party Authority)

PATIENT'S DETAILS

Surname:

Forename:

Address:

Date of Birth: Male/Female:

Third party details

Surname:

Forename:

Address:

Date of Birth: Male/Female:

Contact number:

I confirm that **I am dissatisfied with the service I received at Lees Medical Practice** and I **consent** for the person (s) above to make a complaint on my behalf

Patient signature:

Date:

Once you have completed the form please return to reception. We do require proof of ID to confirm the patient's identity and the third party.