FORM OF AUTHORITY TO PROVIDE MEDICAL INFORMATION IN RELATION TO DEALING WITH A COMPLAINT

|  |  |
| --- | --- |
| **Name of Next of Kin** |  |
| **Address** |  |
|  |
| **Post Code** |  |

|  |  |
| --- | --- |
| **Patient Name** |  |
| **Formerly of**  **Address** |  |
|  |  |
| **Post Code** |  |
| **Date of Birth** |  |

**I formally consent to the disclosure of information concerning their condition, treatment and any other medical information relevant to this complaint only, to:-**

|  |  |
| --- | --- |
| **Complainant Name** |  |
| **Address** |  |
|  |  |
|  |  |
| **Post Code** |  |
| **Telephone numbers** |  |

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Next of Kin Signature)**

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return this form to:**

Complaints and PALS Team

Oak House

Milton Keynes University Hospital NHS Foundation Trust

Standing Way, Eaglestone, Milton Keynes, MK6 5LD

PALS@mkuh.nhs.uk