**FORM OF AUTHORITY TO PROVIDE MEDICAL INFORMATION IN RELATION TO A COMPLAINT**

|  |  |
| --- | --- |
| **Name of Patient** |  |
| **Address** |  |
|  |
|  |
| **Post Code** |  |

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

|  |  |
| --- | --- |
| **Name of person making complaint** |  |
| **Address** |  |
|  |  |
|  |  |
| **Post Code** |  |
| **Telephone numbers** |  |

Signed **(Patient)**

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**