COMPLAINT FORM

UNIVERSITY
HEALTH
SERVICE

(A) Patient's details:

Name: ______________________________

Address: ______________________________

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Date of Birth: ______________ Telephone: ______________

Usual Practitioner ______________________________

(B) Complainant's details (*if different from patient*):

Name: ______________________________

Address: ______________________________

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(C) Details of complaint (including date(s) of events and persons involved):

Complainant's Signature: ______________________________ **Date:** ______________

Where the complainant is <u>not</u> the patient:

I authorise the complaint set out above to be made on my behalf.
I agree that the practice may disclose to the complainant, in so far as is necessary to answer the complaint, confidential information about me from my medical records.

Patient's signature: ______________________________ ***Date:*** ______________

PLEASE RETURN THIS FORM TO: UNIVERSITY HEALTH SERVICE
BUILDING 48, UNIVERSITY OF SOUTHAMPTON, HIGHFIELD, SOUTHAMPTON SO17 1BJ