**CONSENT FORM**

**Please tick**

I wish XXXXXXX [INSERT NAME] NHS North Yorkshire Clinical Commissioning Group (CCG) to investigate my concern/complaint

This form is an authorisation of your consent to the following:

1. If you have requested that the CCG investigate your concerns, you accept we may need to act as an intermediary between the complainant (yourself) and the person/s you are complaining about and contact any relevant parties on your behalf.

If you have specified that the CCG pass on your concerns, we may need to contact the organisation who provided the treatment you are complaining about, e.g. your GP. We may also need to contact other third parties to answer your complaint fully. This could include the hospital or social services.

**Signing this form gives your authorisation to do this.**

1. To allow a named person/s or family member to submit a complaint on your behalf.

You are giving signed consent informing that you wish a named person, e.g. spouse, family member, friend or MP to submit a complaint on your behalf. It may be necessary, in order to answer the complaint fully, to refer to your past/present medical history.

By signing, you are agreeing that your medical information may be shared with your nominated person, if appropriate to do so.

1. Consent to access if necessary, health records in accordance with “releasing health records under the data protection act 1998”.

In order for the appropriate body to complete their investigation and answer your complaint fully, it may be necessary for your service provider to refer to your medical records and/or to provide the CCG with details of your previous medical history, conversations or appointments.

It may be necessary to see past consultations and medical history, which are often relevant to a concern/complaint investigation.

By signing this consent form you are giving consent for the release of medical records to the CCG.

1. You accept that if the appropriate body believes that:
   1. **You might hurt yourself**
   2. **You are in danger**
   3. **Your actions could be dangerous to another person**

we reserve the right to contact the emergency services, your doctor or other people who need to know. We will also share information about you if a court or judge tells us we must.

**I accept the terms outlined within North Yorkshire CCG Consent form**

**PATIENT’S DETAILS**

|  |  |
| --- | --- |
| Patient’s Name |  |
| Patient’s Date of Birth |  |
| Patient’s Address |  |
| Telephone Number |  |
| Mobile Number |  |
| Email Address |  |
| GP Name and Practice Details |  |

**ORGANISATION / HEALTH PROFESSIONAL COMPLAINED ABOUT**

|  |  |
| --- | --- |
| Health professional’s name  and profession *e.g. GP/Dentist* |  |
| Health professional’s  address |  |

**COMPLAINANT’S DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Telephone Number |  |
| Mobile Number |  |
| Email Address |  |
| Relationship to Patient |  |

**I confirm that I parent/guardian of the above:**

|  |  |
| --- | --- |
| Parent/Guardian’s signature of consent |  |
| Date |  |

**Please return this completed form to:**

Email: [nyccg.patientrelations@nhs.net](mailto:nyccg.patientrelations@nhs.net)

Or post using the enclosed SAE