**Ribblesdale Medical Practice – Complaint Form**

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I confirm I would like Ribblesdale Medical Practice to investigate my complaint and provide the necessary permission to: -

* Share my complaint with the persons involved.
* Discuss the complaint at the practice meeting for the purpose of shared awareness raising, learning outcomes and quality improvement.
* Access my medical records for the purpose of reviewing the complaint.
* Receive a response in writing to your home address □ or Email □ (please tick your preferred method)

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| **Your full name (in capitals):** | |  | |
| **Your address:** | |  | |
| **Your Date of Birth:** | |  | |
| **Your home telephone number:** | |  | |
| **Your mobile telephone number:** | |  | |
| **Your email address:** | |  | |
| **Signature:** | |  | |
| **Date:** | |  | |

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| Details of Complaint (continue overleaf) |