Parkgate Medical Centre

Netherfield Lane

Parkgate

Rotherham

S62 6AW

 Tel: 01709 514 501

 Fax: 01709 514 490

**Patient Comments Form**

**Personal Details** (of person making comment)

Name :…………………………..…………………………….. Date of Birth …………………………….

Address: ………………………………………………………………………………………….………....

………………………………………………………………………………………………..………………

Postcode: ………………………………Tel No: .………………………….……………………………..

**Patient Details:** (if different from above)

Name :…………………………..…………………………….. Date of Birth …………………………….

Address: ………………………………………………………………………………………….………....

………………………………………………………………………………………………..………………

Postcode: ………………………………Tel No: .………………………….……………………………..

**Details of the comment, compliment or complaint:**

(Please continue on a separate sheet if necessary)

I hereby authorise the above comments to be made. I agree that members of the practice staff may disclose in so far as necessary, confidential information about me, which I have provided to them.

**Signature: ……………………………….…………………………… Date: ……….…………………………………**

(If you are not the patient, please ask the patient of parent/guardian to sign)

*This does not affect your statutory rights to make a formal complaint to the Health Authority or to seek independent advice. If you wish to complain to the Health Authority, you must do so within 13 weeks of the event*.