INVICTUS MEDICAL SERVICES LTD

CONSENT FORM

Full name of patient: _____

Address: _____

_____

_____

Patient Signature _____

Name of Legal Guardian: _____
(If patient unable to sign)

Address: _____

_____

_____

Contact telephone number: _____

Signed (Legal Guardian): _____ **Date:** _____

I hereby authorise

Name of person making complaint: _____

Relationship to patient: _____

Address: _____

_____

_____

Signed: _____ **Date:** _____

Contact telephone number: _____

I also consent to Invictus Medical Services corresponding with, and disclosing to, the person named above all relevant information, including any sensitive personal information within the meaning of the Data Protection Act 1998.

If you require any help in completing this form, please contact us on
invictusmedicalservices@gmail.com
If you do not have access to the internet please contact us on : 07983 677800 and we will arrange for you to be able to submit your complaint by post.

Please return this form to: invictusmedicalservices@gmail.com

Complaint Ref (office use only):