HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

When a complaint is made on behalf of another person,
THE PERSON WHO RECEIVED THE CARE MUST COMPLETE THIS FORM

If completing by Post - please complete and return to:

Complaints Assessment Team
Office of the Health and Disability Commissioner
PO Box 1791
AUCKLAND 1140

If completing by Complaint Form - please upload this form:
(Please note we do not accept complaints via email)

I ……. write to confirm that:

(*Tick relevant boxes below*)

	I am aware of, and support Consumer's complaint about the care provided to me by …….. (Provider Name); and

	I consent to the Office of the Health and Disability Commissioner (HDC) releasing my personal and health information to Complainant to enable them to participate in HDC's process.

Signed:_____
Consumer

Date: _____

HEALTH & DISABILITY COMMISSIONER
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EXECUTOR OF ESTATE CONSENT FORM

If completing by Post - please complete and return to:

Complaints Assessment Team
Office of the Health and Disability Commissioner
PO Box 1791
AUCKLAND 1140

If completing by Complaint Form - please upload this form:
(Please note we do not accept complaints via email)

I …….. [Name of Executor] am the executor of

…… [Name of Consumer] estate.

I write to confirm that I am aware of and support …….. [Complainant] complaint about the care provided to the Consumer by

…… [Provider].

I consent to the release of the consumer personal health information to the complainant.

I have attached a copy of the portion of Consumer's will authorising me as their executor.

Signed: _____

Date: _____