# 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 the Scottish Ambulance Service 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 0131 314 0000**

**Please return this form to:**
**Scottish Ambulance Service**
**Patient Experience Team**
**1 South Gyle Crescent**
**Edinburgh**
**EH12 9EB**

Complaint Ref (office use only):