PATIENT CONSENT FORM

I hereby give authorisation for:

Name: MR S E MILLAR CHIEF OFFICER

Address: WESTERN HEALTH & SOCIAL SERVICES COUNCIL
HILLTOP, TYRONE & FERMANAGH HOSPITAL,
OMAGH, Co. TYRONE, BT79 0NS.

to act on my behalf and to receive any and all such information as may be relevant to my complaint.

I understand that any information disclosed about ~~myself~~ LUCY is confined to that which is relevant to the investigation of the complaint and only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint.

Full Name: NEVILLE CRAWFORD

Address: [redacted]

Date of Birth: OVER 21

Relationship to person making complaint on my behalf: FATHER

PATIENTS

Signature of Patient: N Crawford

Date: 22-9-00