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Form 177

Authorization for Representation – BCCNM Complaint Process

Instructions

Use this form to authorize someone to act on your behalf in the BCCNM complaints process. This may involve sharing your personal health information.

Complete the section (Part A, B, C, or D) that best describes your situation and return to complaints@bccnm.ca. Incomplete forms may delay the processing of your complaint.

The information collected in this form is used to process your complaint and is collected in accordance with the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c. 165, s. 26(c), 32(a) and 33(2)(d). If you have questions, contact BCCNM at 604-742-6200 or email complaints@bccnm.ca.

Part A – No patient consent

I am submitting this complaint without the patient's consent, or I do not have legal authority to act on their behalf.

Complainant signature: _____ Date (*mm/dd/yy*): _____

Part B – Patient authorization (age 12 or older)

I authorize my representative to submit this complaint and to communicate with BCCNM on my behalf. I understand that this may include sharing information about my health or care. I understand I may withdraw this authorization at any time by contacting BCCNM in writing.

Patient name (*printed*): _____

Patient signature: _____ Date (*mm/dd/yy*): _____

Part C – Representative for a child under 12 or an adult who cannot consent

I confirm that I have legal authority to act on behalf of the patient. I have attached documentation confirming my authority (e.g., custody agreement, court order, medical letter, or representation agreement).

Representative name (*printed*): _____

Representative signature: _____ Date (*mm/dd/yy*): _____

Part D – Deceased patient

I confirm that the patient is deceased, and I have legal authority to act on their behalf.

- ◯ I have attached with this form a copy of the will, letters of probate, or letters of administration naming me as the representative, or
- ◯ I have attached with this form proof that I am the next of kin (e.g., spouse, adult child, parent, sibling).

Representative name (*printed*): _____ Relationship to patient: _____

Representative signature: _____ Date (*mm/dd/yy*): _____