DATA SUBJECT REQUEST FORM

Practice Name: Wimborne Osteopathic Clinic

You have a right to receive a copy of the data/information we hold about you or to authorise someone to act on your behalf. Please complete this form and provide proof of your identity. Your request will be processed within 30 calendar days on receipt of a fully completed request form with proof of identity.

Proof of identity: We require proof of your identity before we can disclose your personal data. Proof of your identity should include a copy of two documents such as your birth certificate, passport, driving licence, an official letter dated not older than 90 days to you at your address e.g. bank statement, recent utility bill or council tax bill. The documents should include your name, date of birth and current address. If you have changed your name, please supply relevant documents evidencing the change. No administration charge is applicable for your first request.

SECTION ONE

Title:	Name of Data Subject:
Address:	
City:	
Postcode:	
Daytime telephone numbers:	
Date of birth:	

If you are not the data subject and you are applying on behalf of someone else, please **also** fill in the extra details below.

Title:	Your Name:
Address:	
City:	
Post Code:	
Day time telephone numbers:	
Date of birth:	
What is your relationship to the data subject? (e.g. parent, carer, legal representative)	
Please provide Letter of authority [ ] or copy of Lasting or Enduring Power of Attorney [ ] Evidence of parental responsibility [ ] or other formal information enclosed [ ]	

SECTION TWO

I am enclosing two items from the following, one of which is photographic as proof of my identity: Birth certificate [ ] Driving Licence [ ] Passport [ ] An official letter to my address not older than 90 days [ ]

DATA SUBJECT'S DECLARATION

I certify that the information provided on this form is correct to the best of my knowledge and that I am the person to whom it relates. I understand that you are obliged to confirm proof of identity/authority and it may be necessary to obtain further information in order to comply with this subject access request.	
Name:	
Signature:	Date:

ON BEHALF OF A DATA SUBJECT

I confirm that I am legally authorised to act on behalf of the data subject. I understand that you are obliged to confirm proof of identity/authority and it may be necessary to obtain further information in order to comply with this subject access	
Name:	
Signature:	Date:

PERSONAL INFORMATION REQUESTED

Please indicate what information is sought and if possible any supporting details such as the year or the reason for the request:
Warning: Anyone who unlawfully obtains or attempts to obtain data is guilty of a criminal offence and is liable to prosecution.

DATA FORMAT

[ ] Please send the information in electronic format

[ ] I would like to receive this information by post*
[ ] I will collect the information in person
[ ] I will go through the information with a member of staff

* Please be aware that if information is posted, we will take every care to ensure that it is addressed correctly. However, we cannot be held liable if the information is lost in the post or incorrectly delivered or opened by someone else in your household. Loss or incorrect delivery may cause you embarrassment or harm if the information comprises of special category data.

Please send your completed form and proofs of identity to:

Wimborne Osteopathic Clinic Limited
11 Leigh Road
Wimborne
Dorset
BH21 1AB
01202 888439