ÖZEL ALANYA ŞİFA MEDICAL CENTER

PERSONAL DATA ACCESS REQUEST FORM

APPLICANT INFORMATION	**T.R. ID / Passport No.**	
	Full Name	
	Date of Birth	
	Phone Number	
	Address	
	☐ I am the Data Subject (I am requesting my own personal data) ☐ I am a Relative / Representative of the Data Subject **Degree of Relationship:** ..... * If you are a Legal Representative, please attach the relevant court decision or power of attorney. * For identity verification and the security of your personal data, an ID card, passport, etc. may be requested.	

RELATIONSHIP WITH THE INSTITUTION

Your Relationship with Our Institution

☐ Patient / Patient Relative ☐ Employee / Former Employee / Applicant
☐ Supplier / Contractor Employee

For Patients	For Employees	For Suppliers
Last Department Visited: ..... **Last Visit Date:**	☐ **Current Employee** **Employment Period (Former Employee):** ..... **Application Year (Candidates):**	**Company Name:** ..... **Position in Company:** .....

REQUEST DETAILS

Please provide a detailed description of the personal data you are requesting and share any information you have regarding the location of the data.

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Select Delivery Method for Response

☐ I would like it sent to my Postal Address ☐ I would like it sent to my E-Mail Address ☐ I would like to collect it in person

Applicant		Institution	
Request Date	:	**Date Received**	:
Full Name	:	**Received By (Full Name)**	:
Signature	:	**Signature**	:

(Document Code to be Entered)