



Data Subject Access Request (DSAR) Form

Requestor Information

Full Name _____

Relationship _____ (Customer, Vendor, Employee, etc.)

Department _____ **(For Employee only)**

Email _____

Contact Number _____

Request Type and Description

Please select the right(s) you wish to exercise.

- | | |
|--|---|
| <input type="checkbox"/> Right to Access and Obtain Copy | <input type="checkbox"/> Right to Restrict Processing |
| <input type="checkbox"/> Right to Rectification | <input type="checkbox"/> Right to Object the Collection of Data |
| <input type="checkbox"/> Right to Erasure | <input type="checkbox"/> Right to Withdraw Consent |

Please provide details to help us process your request (e.g. specify which data, timeframe, systems involved):

By signing below, I confirm that the information provided is accurate and that I am the data subject or authorized to act on their behalf. I understand that the company may require identity verification before processing this request.

Signature _____

Name _____

Date ____ / ____ / ____

For Pacific Healthcare Internal Use

Action Taken Approved
 Rejected due
to _____

Received By _____

Date Received _____

Completed By _____

Date of completion _____