Contact Form for Data Protection

Please let us know which data protection right you would like to exercise.
Please select the type of request and mark it with a cross.

Inquiry type selection

□ Information □ Deletion □ Objection

Additional Information

Please briefly explain your request.

Your contact information	
First Name	
Last Name	
Date of Birth	
Email Address	
Phone	
Street & House Number	
Postal Code & City	
Country	
Provision of your proof of identity	Please create a clear and legible copy of your valid proof of identity. You must attach this to your request for authentication

Please briefly explain your request.

Contact to OCP Quirino	
In what way have you been in contact with the OCP Quirino practice?	

.....	.....	.....
City, Date	Name in block letters	Signature

Please print out this form, fill in all the details, and sign the request. Then, send the completed and signed form along with a copy of your proof of identity by post to:

Osteopathic Medicine Medical Center OCP Quirino
Antonio Quirino
Grütstrasse 55
8802 Kilchberg