1106 Winnipeg Street
Regina, SK S4R 1J6
T. 306.543.7880
F. 306.543.6888 Med.
F. 306.543.5545 Bus

www.reginacommunityclinic.ca

The attached request form provides the Regina Community Clinic with authorization to retrieve and provide, to you or your designate, a copy of the personal health information outlined in your request.

Online Requests

If you would like copies from your health record, please complete the request form and email the form to medrecord@reginacommunityclinic.ca. The medical records team will contact you by email or telephone within two business days of receiving the request.

Clinic Requests

If you prefer not to email the request, you may drop off the form at the clinic. Once you arrive at the clinic, please call the department at 306-543-7880 prompt #7 and one of our team members will come outside and retrieve the form. The form can also be mailed to: Regina Community Clinic
1106 Winnipeg Street
Regina, SK S4R 1J6

If your request is time sensitive, please advise us and we will work with you to meet your needs.

We require that you, or your designate, provide Government issued identification (Drivers License, Health Card, Passport, etc.) when you come to collect the documents. This is to ensure your privacy is maintained.

There may be a fee for the documents.

Standard fees: $0 for four or less pages

$5.00 plus .25¢ per page for five or more pages

Created:2020-09-28

Revised from the Saskatoon Community Clinic

1106 Winnipeg Street
Regina, SK S4R 1J6
T. 306.543.7880
F. 306.543.6888 Med.
F. 306.543.5545 Bus

www.reginacommunityclinic.ca

Medical Record Request

Patients Information

Last name ____________________________________ **First Name** _________________________________

Date of Birth (MM/DD/YYYY) ______________________ **Health Card #** ___________________________

Phone # _______________________ **Street Address** ____

Signature _________________________________ **Date (MM/DD/YYYY)** ____________________________

Information Requested (Please specify the date(s))

Investigations

☐ X-Ray ____________________ ☐ CT Scan ____________________ ☐ ECG ______________________

☐ Ultrasound ______________ ☐ MRI _______________ Other _______________________________

☐ **Laboratory** ____

☐ **Consultation with** ____

☐ **Other** ____

Person Authorized to Receive this Information on my Behalf (Complete only if applicable)

Last Name ___________________________________ **First Name** __________________________________

Full Address ____

Phone # _____________________ **Relationship to Patient** _______________________________________

Signature of Authorized person ____________________________________ **Date** ____________________

Office Use Only

Date Request Received ________________ **Date Copies Provided** __________________

Identification Provided ☐ **Type of ID** ________________________ **Payment Due $**_______

Signature ____