

Please complete all sections and submit the original form to *Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.*

<b>A. Request</b>			
I/We, _____, hereby request and authorize Group Medical Services (GMS) to release a copy of the information described below to myself/ourselves:			
Information Requested		For the dates shown below (DD/MM/YYYY)	
I/We understand and agree that:			
1. I am (we are) only entitled to personal and personal health information for myself/ourselves and my/our dependants under the age of 18. Information about a third party will require their written consent.			
2. GMS will charge a fee for gathering and providing this information and I/we agree to pay all such fees prior to receiving the information requested.			
3. GMS has the right to confirm my identity prior to providing this information.			
<b>B. Personal Information</b>			
In order for GMS to verify my (our) identity, I am (we are) providing the following information:			
First Name	Last Name	Date of Birth (DD/MM/YYYY)	
Address	City	Province	Postal Code
Phone (        )	GMS ID No.		
Signature <b>X</b>	Date (DD/MM/YYYY)		
<b>C. Fee Schedule and Payment Options</b>			
If you are requesting Personal Information and/or Personal Health Information about yourself, the following fees will apply:			
Description	Fee		
<i>Electronic Information for current policy year and two (2) previous policy years.</i>	<i>No charge for first request per year; \$25.00 per request for each subsequent request.</i>		
<i>Electronic Information for any additional year(s).</i>	<i>\$25.00 per year requested<sup>1</sup> + \$0.50 per page printed or copied.</i>		
<i>Any information that must be retrieved from paper files.</i>	<i>\$25.00 per year requested<sup>1</sup> + \$0.50 per page printed or copied.</i>		
<sup>1</sup> Required fee payable in advance. The per page fee is payable upon request of information.			
Payment Amount \$	<input type="checkbox"/> Cheque <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard		
Credit Card Number	Expiry Date (DD/MM/YYYY)		
Signature of Card Holder <b>X</b>			