Saskatoon Community Clinic

Community Health Services (Saskatoon) Association Ltd.

455 Second Avenue North, Saskatoon, Saskatchewan S7K 2C2 Phone (306) 652-0300 Fax (306) 664-4120

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

If you would like copies from your clinic health record please complete the request form and email it to HIM@communityclinic.ca. The Health Information Management team will contact you by email or telephone within two business days of receiving the request.

If you prefer not to email the completed form you may drop it off at the Main Clinic Reception desk or mail to: Saskatoon Community Clinic
Health Information Management
455 2nd Avenue North
Saskatoon, SK S7K 2C2

We will contact you within two business days of the drop off. 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 (if applicable), provide Government issued identification (i.e. Driver's License, Health Card, Passport, etc.) when you come to the clinic to pick up your documents. This is to ensure that your privacy is maintained.

There may be a fee for the documents.

Standard fees: $0 for five pages or less
$5.00 plus 10¢ per page for six or more pages

It is our goal to help you navigate your health concerns. If cost is prohibitive we will work to meet your needs.

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Health Record Request

Patient Identification Information

Last Name _____ First Name _____

Date of Birth _____ Health Care # _____

Telephone _____ Address _____

Signature _____

Information Requested (please specify the date(s) required)

☐ Laboratory _____ ☐ ECG _____

☐ X-Ray _____ ☐ Hospital Reports (specify) _____

☐ CT Scan _____ _____

☐ MRI Scan _____ ☐ Consult With _____

☐ Ultrasound _____ ☐ Visit _____

☐ Other _____ ☐ Other _____

Person Authorized to Receive this Information on My Behalf (complete only if applicable)

Last Name _____ First Name _____

Address _____

Street Number and Name City Province Postal Code

Phone Number _____ Relationship to Patient _____

Signature of Authorized Person _____

Office Use Only

Date Request Received _____ Date Copies Provided _____

☐ ID Checked - Type of Identification Provided _____ Payment Due _____

Signature _____

Date of Examination (Viewing) _____ Provider(s) Informed ☐