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RELEASE OF INFORMATION
Request Form

Please complete all sections and submit to GMS at 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3 or scan and email to info@gms.ca

A. Request

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. Personal Information

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 **X**	Date *(DD/MM/YYYY)*		

C. Fee Schedule & Payment Options

If you are requesting Personal Information and/or Personal Health Information about yourself, the following fees will apply:

Description	Fee
Electronic Information for current policy year and two (2) previous policy years.	No charge for first request per year; $25.00 per request for each subsequent request.
Electronic Information for any additional year(s).	$25.00 per year requested[1] + $0.50 per page printed or copied.
Any information that must be retrieved from paper files.	$25.00 per year requested[1] + $0.50 per page printed or copied.

[1] *Required fee payable in advance. The per page fee is payable upon request of information.*

Payment Amount
$

☐ Cheque ☐ Visa ☐ MasterCard

Credit Card Number	Expiry Date *(MM/YYYY)*

Signature of Card Holder
X