

MEDICAL STATEMENT REQUEST APPLICATION

Medical Statements are listings of physician services, the date of service, and the community where the service was provided, and services received in the hospital. Completion of this application allows Medical Services to request this information on your behalf.

Please fill out one application per person requiring a medical statement

Applicant Information			
Family Name		Given Name	
Date of Birth (DD-MM-YYYY)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Health Services Number (9 digit)	
Apt. No.	Number and Street, Concession, Other	City or Town	
Province/State	Country	Postal Code (if in Canada)	
Contact Phone Number (10-digit)			
Please select the statement that you require: <input type="checkbox"/> Physician Statement <input type="checkbox"/> Hospital Statement			
Section 1 – Relationship to Applicant			
A - <input type="checkbox"/> - Children under 18 years of age - Parents MUST sign request			
B - <input type="checkbox"/> - Other (specify) _____			
Is the Power of Attorney (POA) or Executor signing on behalf of the applicant? YES <input type="checkbox"/> NO <input type="checkbox"/>			
YES , then copies of the POA or copy of Will or Letter of Administration documents <u>MUST</u> be attached _____			
PRINT NAME IF GUARDIAN/TRUSTEE/POWER OF ATTORNEY/EXECUTOR/WITNESS			
Section 2 – Third Party Agency Release (if applicable)			
You are hereby authorized to provide my medical records from _____ to _____ as requested by _____.			
Section 3 – Request Information			
Time Frame (i.e. January 1, 2014 to December 31, 2014)			
Section 4 – Signature (REQUIRED)			
Signature of Applicant _____ Date _____			
Please circle one of the following APPLICANT/GUARDIAN / TRUSTEE / POWER OF ATTORNEY/EXECUTOR/WITNESS A witness is necessary if Applicant signs with an “X” or a mark.			