Request for Historical/Physician Information

DATE OF REQUEST *(mm/dd/yyyy)*: ______________________________

NAME OF CLIENT (Please print)**:** ______________________________

Check one: ☐ *Media* ☐ *Family Member* ☐ *Organization* ☐ *Member of the Public*

CONTACT INFORMATION (Delivery address, if applicable)		
Street, PO BOX, APT#		
City/Town	Postal Code/Zip Code	Country
Email		

SEND PAYMENT RECEIPT TO: ☐ same e-mail as above ☐ I do not need a receipt
Email

I would like Information on (please describe):

ADDITIONAL DETAILS *(If your inquiry is about a physician, please fill out this section):*

Full name of physician (first/middle/last): ______________________________

Date of birth (if known): ______________________________

Approximate date(s) of active practice (if known): ______________________________

Reason for Request:

☐ *Historical research/publication*
☐ *Personal use/family information*
☐ *Media story*
☐ *Employment/background check*
☐ *Disciplinary Investigation*
☐ *Other (provide a separate document with an explanation)*

ACKNOWLEDGEMENT

I UNDERSTAND THAT BY SIGNING THIS FORM, I AGREE TO THE FOLLOWING:

- The credit card number I provide will be charged a base fee of $60, payable in advance of service, for each request.
- I will not be charged if the College has no information on file pertaining to my request.
- The College is bound to respect the Health Information Protection Act as well as restrictions imposed by the Council on releasing information that the College considers to be confidential. The College may therefore redact part of the content of the file before providing any information to you. The College also cannot provide any guarantee concerning accuracy or completeness of the information that is held within the file.
- Depending on the amount and nature of information to be processed, additional costs may be incurred (for example with large files or for documents where redaction of information is necessary), and a new credit card authorization form may need to be filled out for a different amount. The College will advise me in writing in advance of any additional costs associated to my request, obtain approval from me in writing to charge my credit card and obtain full payment prior to proceeding with my request.
- Depending upon the nature of the request, it may take days or weeks for the College to order the necessary files from its secure off-site storage facility and process the information received for distribution. An additional amount may be charged for rush orders.

SIGNATURE: ____ DATE (mm/dd/yyyy): ____________________________

FOR OFFICE USE ONLY		
	By Whom	**Date**
Request received		
File ordered		
File received		
Scanned		
Information Processed		
Reviewed and approved		
Final response sent to requesting client		

PAYMENT INFORMATION AND AUTHORIZATION

I, ____

(Cardholder's Name – Please Print)

authorize the College of Physicians and Surgeons of Saskatchewan to charge my credit card for the amount stated below

Amount Authorized: $ ______________

Cardholder Signature: ____

Please print and sign manually. Electronic signatures not accepted.

Name as it appears on card: ____

Credit Card Number: | | | | | | | | | | | | | | | | |

**Visa Debit and other debit cards are not accepted.*

Expiration Date: | | | | | ☐ Visa ☐ MasterCard

PRINT, SIGN, FAX OR HAND DELIVER THIS FORM TO:

Fax: (306) 244-0090
College of Physicians and Surgeons of Saskatchewan
101-2174 Airport Drive, Saskatoon, SK S7L 6M6