DAWSON HEIGHTS
MEDICAL CLINIC

109-109 Regina Ave
Thunder Bay Ontario, P7B 2B4
807-344-0105

Date of Request (DD/MM/YYYY) : ____ / ____ / _____

Patient Details:

Full Name: _____
Date of Birth (DD/MM/YYYY) : ____ / ____ / _____
Address: _____
Phone Number: (_____)_____
Email Address: _____

Request Details:

- ☐ All Records
- ☐ Specialist Reports
- ☐ Imaging Results
- ☐ Office Visit Notes
- ☐ Laboratory Results
- ☐ Other (please specify): _____

Date Range for Requested Records:

From: ____ / ____ / _____ To: ____ / ____ / _____

Preferred Format for Records:

- ☐ Paper Copy ($30 for first 20pgs + $0.25 per additional pg + HST)
- ☐ Email (small requests only, unable to send large files) (flat rate of $30 + HST)
- ☐ Chart Copy on USB (flat rate of $40 + HST)

* Please be advised, we are unable to accept USB's provided by patients due to privacy and security reasons. We will issue a new USB to you for your request. *

Preferred Delivery Method:

- ☐ Pick-up In Office
- ☐ Mailed to the Address Provided Above (will require payment before we can mail out)
- ☐ Emailed (Only for small file sizes; will require payment before we can send out)

We accept debit, credit and cash for payments.

Will you be picking up your records yourself?

- ☐ Yes
- ☐ No

If no, please specify your authorized representative: _____

Authorization Statement:

I hereby authorize Dawson Heights Medical Clinic to release the above-selected medical records to myself or my authorized representative. I accept the fees associated with my request, as outlined above, and I acknowledge that they are my responsibility as the patient.

Patient Signature: _____

Date: ____ / ____ / _____