

Medical Statement Request Application

Submit request to:
 Ministry of Health, Medical Services Branch
 2nd Floor – 3475 Albert Street Regina, SK S4S 6X6
 Toll free: 1-800-667-7523 or 306-798-0013
 FAX: 306-798-1124 Email: prss@health.gov.sk.ca

Medical Statements are a list of insured services that have been paid on your behalf by the Ministry of Health. This includes the provider, location, date and type of service. It is not a medical record. Completion of this application allows Medical Services to request this information on your behalf. Medical Statement Reports will be sent to the address provided through letter mail only.

Please complete one application for EACH PERSON requiring a medical statement

APPLICANT INFORMATION (REQUIRED)			
Family Name		Given Name	
Date of Birth (DD-MON-YYYY)		Health Services Number (9-digit health card)	
Mailing Address			City or Town
Province	Country		Postal Code (if in Canada)
Contact Phone Number (10-digit)	Contact Email		
Please select the statement that you require: <input type="checkbox"/> Physician Statement <input type="checkbox"/> Hospital Statement			
SECTION 1 – Time Frame Requested (REQUIRED)			
Start date (DD-MON-YYYY)		End date (DD-MON-YYYY)	
SECTION 2 – Representative of Applicant (if applicable)			
Name of Representative:			
<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> TRUSTEE <input type="checkbox"/> POWER OF ATTORNEY <input type="checkbox"/> EXECUTOR			
<input type="checkbox"/> A – For children under 18 years of age: Parent / Guardian MUST sign request and Guardian MUST provide guardianship documentation <input type="checkbox"/> B – Power of Attorney (POA) or Executor - complete copies of the POA or copy of Will or Letter of Administration documents MUST be attached <input type="checkbox"/> C – Other (specify): _____			
SECTION 3 – Third Party Agency Release (if applicable)			
I hereby authorize the Ministry of Health to release my medical statement to a third party as indicated below:			
Name		Company	
Mailing Address			
SECTION 4 – Signature (REQUIRED)			
Signature of Applicant _____		Date _____	
*Witness is required if Applicant signs with an “X” or mark.			
Please check one of the following:			
<input type="checkbox"/> APPLICANT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> TRUSTEE <input type="checkbox"/> POWER OF ATTORNEY <input type="checkbox"/> EXECUTOR			

Please note: Requests dating prior to October 1, 1991, will have fees associated per fiscal year requested, which must be paid in advance payable to the Minister of Finance before the request will be completed.

MEDST – 04-14

January 2026