

Physician Consent

The information you provide on this form is collected under the authority of section 20 (b) of the *Health Information Act* and is in accordance with the *Freedom of Information and Protection of Privacy Act*. The information will be used for the purpose of creating and providing standardized Primary Care Network Business Planning Reports to assist the Primary Care Network with its business planning process. If you have any questions about the collection of this information, you may contact the Alberta Health and Wellness, Master Physician Budget & Utilization (MPBU) unit at (780) 415-0218 or (780) 415-1472.

Print Name of Physician	Practitioner ID Number
Name of Primary Care Network	
Name of Primary Care Network's Principal Contact	

Consent (Please check appropriate box below.)

All references to the Primary Care Network and the Primary Care Network's Principal Contact refer to those named above.

- I have signed a Letter of Intent regarding participation in the Primary Care Network;
- I am a Locum Physician and providing services to patients who may be enrolled by the Primary Care Network;
- I am not a signatory to the Letter of Intent but I may refer my patients to the Primary Care Network for their continuous care and potential enrolment.
- I am interested in becoming a Participating Physician or an associate provider in the Primary Care Network and have not signed a Letter of Intent.

I hereby authorize the Primary Care Network's Principal Contact to disclose my first name, surname and practitioner identification number to Alberta Health and Wellness. I further authorize Alberta Health and Wellness to provide the Primary Care Network's Principal Contact non-identifying health information about the health services that I have provided for business planning purposes.

I understand the information collected pursuant to this consent shall only be used by the Primary Care Network's Principal Contact for the purpose of assisting the Primary Care Network with its business planning processes and will not be used in data matching. Any use or disclosure shall be in compliance with the *Health Information Act, the Freedom of Information and Protection of Privacy Act and the Personal Information Protection Act*.

I acknowledge that I have been advised of and understand the reasons why this health information is needed and the risks and benefits to me of providing or refusing to provide my consent.

This consent is effective immediately and terminates the earlier of (a) when I revoke it or (b) if the business plan for the Primary Care Network has not yet been approved, when such business plan has been approved by the Primary Care Initiative Committee. I may revoke this consent by completing the bottom of this form and faxing it to the Manager, Alberta Health and Wellness, Master Physician Budget and Utilization unit at fax number (780)422-5208.

Signature of Physician	Date
X	

Revocation of Consent

I hereby revoke the above Consent.

Signature of Physician	Date
X	