Alberta Government

Physician Consent form for Clinical Alternative Relationship Plan Application

I, the undersigned, authorize Alberta Health to collect and use information on the Alternative Relationship Plan (ARP) application and to disclose information to its agents, and related stakeholder organizations, committees, or working groups (Alberta Health Services, Alberta Medical Association, and the ARP – Program Management Office) for the following purposes:

- Evaluation of the ARP Application form, plus appendices if any, including but not limited to billing, invoicing, claim processing, monitoring and reporting information (e.g. practitioner identifying numbers (Prac. IDs), specialty designations, skill codes, etc.)
- Administration and management of any resulting primary care physician compensation.

The information will be collected, used, and disclosed pursuant to the following authorities:

- To collect information pursuant to sections 19, 20(a) and (b) of the *Health Information Act*, section 33(c) of the *Freedom of Information and Protection of Privacy Act*, and section 7(1) and 11 of the *Personal Information Protection Act (PIPA)*.
- To use information pursuant to sections 26, 27(1)(c)(f), 27(2)(a)(b)(d) of the *HIA*, section 39(1)and 39(4) of the *FOIP Act*, and section 16 of the *PIPA.*
- To disclosure information pursuant to sections 34, 35(1)(a), 39(1)(2) of the *HIA*, section 40(1)(a)(c)(d)(e)(l)(bb)(bb.1), 40(4), 41 of the *FOIP Act*, and section 19 of the *PIPA.*

I acknowledge that I have been made aware of the reasons why my personal information is collected and understand the purpose for which my information will be used and disclosed as it relates to the evaluation of the ARP application as well as the administering and managing of any resulting primary care physician compensation.

I understand that this Consent, effective the date stated below, does not have an expiry date, but that I may revoke this Consent at any time in writing. I acknowledge that if I revoke this Consent, Alberta Health, its agents, and related stakeholder organizations, committees, or working groups will cease disclosing the stated information effective from the date Alberta Health, its agents, and related stakeholder organizations, committees, or working groups receive my revocation. Alberta Health, its agents, and related stakeholder organizations, committees, or working groups shall not have any obligation to retrieve copies of this information already disclosed.

Effective this _____ day of _____, 20__.

_____ Proposed Alternative Relationship Plan Program Name	_____ Practitioner ID of Consenting Physician
_____ Printed Name of Consenting Physician	_____ Printed Name of Witness
_____ Signature of Consenting Physician	_____ Signature of Witness

Questions related to the Alternative Relationship Plan Application:
Program Director
ARP Program Management Office
12230 - 106 Ave NW
Edmonton, AB T5A 4K5
Phone: 780-453-3130
Toll-free: 1-866-953-3130
Fax: 780-453-3599

Questions related to collection/use/disclosure of this information:
Director, Program Design and Delivery
Alberta Health
P.O. Box 1360, Station Main
Edmonton, AB T5J 2N3
Phone: 780-638-3193