

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 ARP Physician Support Services) 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:**

Director, ARP Physician Support Services  
Alberta Medical Association  
12230 - 106 Ave NW  
Edmonton, AB T5A 4K5  
Toll-free: 1-866-953-3130  
Email: arpinquiries@albertadoctors.org

**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