Agreement to Participate

I agree to participate in the following quality improvement initiative/program(s):

- ☐ Screening and Prevention (ASaP)
- ☐ Tobacco (pcnACT)
- ☐ Other: _____

In agreeing to participate, I am aware of the following:

1. I will allow the disclosure of non-identifiable, aggregate patient data from the review of patient charts as per Section 32(1) of the Health Information Act in order to facilitate a quality improvement analysis.
2. The email address I provide will receive my personal reports and communications from TOP.
3. My personal reports will also be sent to my facilitator for improvement, not judgement.
4. No individually identifiable patient information will be collected, used, or disclosed at any time during the undertaking of this quality improvement initiative.
5. In addition, I agree to have my information included as part of the overall aggregate data which will be used for project reporting and no personal identifiable information will be disclosed.

Information Purposes

Your facilitator may ask you for:

1. Some basic information regarding you and your practice to understand the current state in your clinic setting.
2. Meeting time with you and other members of your clinic to facilitate your identified quality improvement initiative.
3. Feedback when developing processes for you and your clinic team.

Provider Signature

I understand that I may change my decision regarding the above at any point in the future by providing a written or email notice to Accelerating Change Transformation Team (ACTT).

_____ _____

Print Name Date

_____ _____

Signature PCN Name (if applicable)

NOTE: Please forward this completed document to asap@albertadoctors.org and your PCN, if applicable.