CONSENT FOR DISCLOSURE OF NON-IDENTIFYING HEALTH INFORMATION

I, _____, give consent to the Sherwood Park-Strathcona County Primary Care Network to disclose aggregated health information collected during my participation in the CHANGE Program (Canadian Health Advanced by Nutrition and Graded Exercise). The information to be shared may include anthropometrics, lab results, subjective assessments (diet, nutrition and mental health), fitness assessment, blood pressure and a CV risk calculation.

I am aware that this aggregated data may be shared with my physician, other CHANGE participants and/or other CHANGE participant's physicians for the purpose of evaluating the effectiveness of the program and group progress.

The risks of sharing this information are none as no identifiable information is given. The benefits would be that administrators, patients and physicians learn about the effectiveness and areas of improvement for the program.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release.
I understand that I may revoke my consent at any time, by providing a signed, written statement to that effect.

Date:_____

Signature: _____Print Name: _____