APPENDIX G-2

FAMILY HEALTH NETWORK CONTRACTED PHYSICIAN CONSENT TO DISCLOSURE OF BILLING AND FINANCIAL INFORMATION

TO: THE GENERAL MANAGER OF THE ONTARIO HEALTH INSURANCE PLAN (the "**General Manager**")

AND TO: THE MINISTER OF HEALTH AND LONG-TERM CARE (the "**Minister**")

AND TO: THE LEAD FAMILY HEALTH NETWORK PHYSICIAN (the "**Lead FHN Physician**")

I, _____, hereby authorize the General Manager to disclose to the Lead FHN Physician, Dr. _____, the following information relating to amounts paid by the Plan to me for Insured Services rendered by me as of the date of my commencement as a FHN Contracted Physician:

(a) date of service;
(b) fee code for service, where applicable;
(c) amount paid for service; and
(d) base rate payment amounts, where applicable.

This consent shall be valid until I cease being a FHN Contracted Physician, or until the FHN ceases to exist, or until I revoke this consent in writing to the General Manager, whichever may come first.

I acknowledge and understand that the purpose of the disclosure of this information by the General Manager to the Lead FHN Physician is to assist and support the FHN Physicians for financial and administrative purposes.

The terms used in this consent shall have the same meaning as they have in the Family Health Network Agreement.

Dated at _____ this _____ day of _____ , _____.

_____
Signature

_____
Name

_____
Address

_____

_____
Family Health Network