Affiliate Agreement Form

The following custodian/affiliate relationship is being established in accordance with the Health Information Act (Alberta):

Custodian Information	
Physician Name:	**Clinic Name:**
Affiliate Information	
Affiliate Name:	**Address:**

Services to be Provided by Affiliate

The affiliate will conduct a chart review, in accordance with any confidentiality/access/process guidelines established by the custodian, so the custodian may fulfil the requirements of participation in ASaP, which the custodian has agreed to participate in. The affiliate will not provide clinical judgement or advice to the custodian or their staff. While this relationship will end 120 days after the date this agreement is signed, the oath of confidentiality shall continue.

Affiliate Oath of Confidentiality

I, _____, an affiliate of the physician named above hereby swear that I will:

1. Uphold to the best of my ability my duties under the Health Information Act and the regulations and the custodian's policies and procedures.
2. Not disclose or make known any recorded or non-recorded health information of the individual except as authorized by the act, the regulations and the custodian's policies and procedures now or in the future.
3. Not remove any recorded patient health information from the premises of the custodian.
4. Not review any data, patient charts or portions of a patient's chart that does not relate to the purposes of ASaP.
5. Not disclose or make known any information related to the physicians chart review results.

Dated this _____ day of _____, 20_____ at _____.
(city/town/village)

_____ _____
Signature of Affiliate Signature of Witness

_____ _____
Printed Name Printed Name

Physician / Designate Initials _____

Physician / Custodian Declaration

I, _____, as custodian of confidential patient records hereby swear that I will:
(physician or designate)

1. Agree to accept _____ as an affiliate of my clinical practice for the purposes of conducting a chart review so that I may fulfill the requirements of participation in ASaP which I have agreed to participate in.
2. Agree to allow the affiliate access to patient medical records and if necessary booking and billing data for the purposes of conducting a chart review so that I may fulfill the requirements as per #1 above.
3. Agree to clearly define any guidelines, policies or procedures particular to my practice, which are in accordance with the Health Information Act, for purposes of chart reviewing which I wish the affiliate to abide by. It is my duty as the custodian to be forthcoming with this information and not the duty of the affiliate to seek it out or infer it in anyway.

Dated this _____ day of _____, 20_____ at _____.
(city/town/village)

_____ _____
Signature of Physician or Designate Signature of Witness

_____ _____
Printed Name Printed Name

Original – Physician *Copy – Affiliate* *Affiliate Initials* _____

2013/04/04

**This form may be printed from the website*