Masaki Oishi, MD, PA

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Waco, TX 76712
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Authorization Form
For release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below. (please print)

Patient Name ______________________________

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** __________ **Date:** ____________

The health information you may release subject to this authorization is as follows:

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Facility released from:

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PH# ____________ FAX# ____________

Release my protected health information to the following person(s)/entity:

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Telephone: ______________ Fax: ______________

Contact: ______________________________

The reasons or purposes for this release of information are as follows:

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I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice.

Nancy Potts

7030 New Sanger Rd., Suite 200

Waco, TX 76712

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

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Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

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Description of Personal Representative's Authority
(Must be accompanied by a Power of Attorney if
being signed by a personal representative)

Date of Birth: ______________________________

Witness: ______________________________

Date: ______________________________

Expiration Date: ______________________________