David W. Hobson MD Obstetrics
4411 Avenue N.
Rosenberg, TX 77471

Gynecology Infertility & Menopause Medicine
Telephone 281-341-6888
Fax 281-341-6583

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient (Please Print) _____ **Social Security #** _____ **Date of Birth** _____

Street Address _____ **City, State, Zip** _____

Maiden or other names used for records _____ **Date this authorization expires (*if no expiration date indicated Authorization will expire 1-year from the date of signature)*** _____

Release From:

Name (Please Print) _____

Address _____

City, State, Zip _____

Released To:

Name (Please Print) _____

Address _____

City, State, Zip _____

The following protected health information is to be disclosed: (*please check all that apply)*

___ Complete health record **___ Insurance Info** **___ Billing Statement** **___ Lab Results**
___ Surgical notes **___ Radiology Results** **___ Progress Notes** **___ Chemical Dependency Results**
___ Pregnancy records **___ HIV Test Results** **___ Medical History**
___ Other _____

Covering the period from _____ **to** _____

Unless specifically indicated, only up to the last three years of records will be copied

Purpose of release: *(please check all that apply)*
___ Transfer of care
___ Moving
___ Continuation of care
___ Other _____

I hereby request for you to release the indicated portions of individually identifiable health information relating to me. This information is referred to as "protected health information" under the federal regulation, known as the "HIPPA privacy rule". This PHI will be used and/or disclosed for the following purpose:
___ Medical Care ___ Insurance ___ Other _____

To: David W Hobson, MD, PA of 4411 Ave. N, Rosenberg, TX 77471
Telephone (281)341-6888 FAX (281)341-6583

I, the undersigned, have read the above and authorize the staff of David W. Hobson, MS, PA to obtain such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hareby release and hold harmless the above named entity from all liability and damages resulting from the lawful release of my Protected Health Information.

Date _____ Signature of Patient/Parent/Guardian _____ Authority/Relationship to Patient _____

Date _____ Signature of Witness _____