David W. Hobson MD Obstetrics
1601 Main Street, Suite 302
Richmond, TX 77469

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**
___ **Pregnancy records** ___ **HIV Test Results** ___ **Medical History** **Results**
___ **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 1601 Main Street, Suite 302 Richmond, TX 77469
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