

David W. Hobson MD FACOG  
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Rosenberg, TX 77471

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### REQUEST BY PATIENT FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request David W. Hobson, MD to copy the records specified below, and mail them to me at:

_____ 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 This form will expire 1 year from the date of signature)	

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

- Complete health record
- Surgical notes
- Pregnancy records
- Other

Covering the period from \_\_\_\_\_ to \_\_\_\_\_

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

You have the right to inspect, or to obtain a copy of your protected health information maintained in the designated record set by David W. Hobson MD PA. Your request must be made in writing using this form. The form must be completed prior to David W. Hobson MD PA providing you the requested information.

David W. Hobson MD PA will make every reasonable effort to provide the protected health information requested in the format requested by you if it is readily producible in such format. If it is not readily producible in such a format, David W Hobson MD PA will make every reasonable effort to provide access to the protected health information in a legible, hard copy format or in such other form as agreed upon by you and David W. Hobson MD PA.

David W Hobson MD PA may provide you with a summary of the protected health information requested, in lieu of providing access to the protected health information, or may provide an explanation of the protected health information to which access has been provided, if you agree, in advance, to the summary and explanation and if you agree, in advance, to the fees imposed for such summary. The fee for copying your protected health information or providing a summary to you is **\$10.00 base fee, plus 25 cents per page, plus any applicable postage.**

I hereby agree to pay David W Hobson MD PA for the cost of copying such records. *Please make checks payable to David W Hobson MD PA.*

Patients Signature: \_\_\_\_\_ Date \_\_\_\_\_

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