

**DAVID W. HOBSON MD, PA  
OBSTETRICS AND GYNECOLOGY**

Oakbend Doctor's Center  
4411 Ave. N,  
Rosenberg, Texas 77471

Telephone 281-341-6888  
Fax 281-341-6583

**Receipt of Notice of Privacy Practices  
Written Acknowledgement Form**

This is to acknowledge that I have read and understand the Notice of Privacy Practices posted in the office of David W. Hobson MD PA of 1601 Main Street, Suite 302, Richmond, TX 77469. The Notice of Privacy Practices provides information about how the office of David W. Hobson, MD PA may use and disclose protected health information about me. As provided in the notice, I understand the terms of the notice may change.

I understand that I have the right to request that the office of David W. Hobson MD PA restrict how protected health information about me is used or disclosed for treatment, payment or health care operations. I understand the office of David W Hobson MD PA is not required to agree to this restriction, but if they do, they are bound by our agreement.

I have read the notice and by signing this form, I have consented to their use and disclosure of my protected health information for treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where they have already made disclosures in reliance on my prior consent. If the office of David W Hobson MD PA make changes to the notice I may review a revised copy by making my requesting in writing. If I would like to request restrictions, I must also send a request in writing. Address for requests & compliance.

David W. Hobson MD PA  
Privacy Officer for David W. Hobson MD PA  
4411 Ave. N  
Rosenberg, TX 77471

\_\_\_\_\_  
Signature of Patient                      Printed Name of Patient                      Date

\_\_\_\_\_  
Signature of Witness                      Printed Name of Witness                      Date

This notice is available in Spanish, please call our office at 231-341-6888  
Si quiere recibir este aviso en español, favor de comunicarse con la oficina al 281-341-6888

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**Office Use Only**

**I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:**

**Date:** \_\_\_\_\_ **Initials:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

**I authorize this office to release any medical information to:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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