FIRST CHOICE
YOUR TRUSTED SERVICE

First Choice Mobile Notary & Apostille
(866) 828-6856
Book an Appointment Online
www.firstchoicenotary.com

How to Complete Your Florida HIPAA Authorization

Authorization to Release Protected Health Information (45 C.F.R. 164.508)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This authorization lets doctors, hospitals, and insurers **share your health information** with the people you name, such as family members or your attorney. It includes the elements required by the federal HIPAA Privacy Rule.

1. **Identify yourself and the provider**
   Enter your name and date of birth, and the doctor, hospital, insurer, or other provider who holds your records. Write “All providers” if you want it to apply to everyone.
2. **Name who may receive your information**
   Enter each person or organization that may receive your health information, such as a family member, attorney, or insurer.
3. **Describe the information, purpose, and end date**
   Check what may be released, state the purpose (“at my request” is acceptable), and choose an expiration date or event.
4. **Sign and date in front of a notary**
   Many providers and insurers accept a notarized authorization more readily. Bring a current, government-issued photo ID.

After It’s Signed

- Give a copy to each provider named and to each person authorized to receive information. Keep the original.
- You may revoke this authorization at any time in writing, except to the extent a provider already acted on it.
- This form lets people receive information only. To let someone make medical decisions for you, use a Florida Designation of Health Care Surrogate.

Need a Notary? We Come to You.

Homes • Hospitals • Care Facilities • Offices
Mobile Notary & Apostille Services
Florida-Commissioned Notaries • Serving Florida

Call us anytime
(866) 828-6856
Book an Appointment Online
www.firstchoicenotary.com

Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Main headquarters: 2315 Capitol Avenue, Sacramento, CA 95816.

This form is provided as a free convenience. First Choice Mobile Notary & Apostille is not a law firm, and a notary public who is not an attorney cannot give legal advice or help you decide what to write on this form. These instructions are general information only and are not legal advice. If you have questions about your situation, consult a licensed Florida attorney. © 2026 First Choice Mobile Notary & Apostille. All rights reserved. This form may be filled in and printed for personal use; it may not be copied, altered, or redistributed for commercial purposes.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(HIPAA, 45 C.F.R. 164.508)

1. PATIENT

Full name of patient | Date of birth | Telephone

Address (street, city, state, ZIP)

2. WHO MAY RELEASE THE INFORMATION

Provider, facility, health plan, or other covered entity (or “All providers”)

Address (if known)

3. WHO MAY RECEIVE THE INFORMATION

Name | Relationship | Telephone

Name | Relationship | Telephone

Name | Relationship | Telephone

4. INFORMATION TO BE RELEASED (check one)

All of my health information and medical records, including billing records.

Only the following information or dates of service:

Description

Unless I initial below, the information released will **not** include the following, which require my specific consent:

☐ Mental health records (other than psychotherapy notes), substance use disorder treatment records, HIV/AIDS test results, and genetic testing information.

5. PURPOSE

Purpose of the disclosure (“at the request of the patient” is acceptable)

© 2026 First Choice Mobile Notary & Apostille • Serving Florida • (866) 828-6856 | www.firstchoicenotary.com

6. EXPIRATION

This authorization expires on the following date or event (if left blank, it expires one year from the date signed):

Expiration date or event

7. MY RIGHTS

- I may revoke this authorization at any time by giving written notice to the provider named in Section 2, except to the extent the provider has already acted in reliance on it.
- My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization, except as permitted by federal law.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy rules.
- I am entitled to a copy of this authorization.

8. SIGNATURE

X _____

Signature of patient or personal representative

Date

Printed name

If personal representative, describe authority (e.g., health care surrogate, parent)

© 2026 First Choice Mobile Notary & Apostille • Serving Florida • (866) 828-6856 | www.firstchoicenotary.com

NOTARY ACKNOWLEDGMENT

State of

County of

The foregoing instrument was acknowledged before me by means of

physical presence or

online notarization,

this day of

month

year

by (name of person signing)

Personally Known OR

Produced Identification

Type of identification produced

X

Signature of Notary Public

(Notary seal)

Print, type, or stamp commissioned name of Notary Public

Commission number

Commission expires

© 2026 First Choice Mobile Notary & Apostille • Serving Florida • (866) 828-6856 | www.firstchoicenotary.com