FIRST CHOICE
MOBILE NOTARY & APOSTILLE

(866) 828-6856
Book an Appointment Online
www.firstchoicemobilenotary.com

How to Complete Your Nevada HIPAA Authorization

Let Family Members Access Your Medical Records and Talk With Your Doctors

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR NEVADA HIPAA AUTHORIZATION.

About this form. Federal privacy law (HIPAA) limits who doctors, hospitals, and insurers may share your health information with. This authorization names the people who may receive your records and speak with your providers. It is often signed with a Nevada Advance Health-Care Directive and Power of Attorney, so your family can help even before you are incapacitated.

1. **Fill in your details**
   Use your full legal name and date of birth, exactly as your providers have them.
2. **Choose who may release information**
   Allow all of your providers and plans, or name a specific one.
3. **Name who may receive it**
   List each person, their relationship to you, and contact information.
4. **Choose what information and why**
   Allow all information or limit it. Mark the box to exclude sensitive categories if you wish.
5. **Set an expiration**
   HIPAA requires an expiration date or event. Choose one that fits your plans.
6. **Sign before a Nevada notary**
   Many hospitals accept a signed copy; notarization adds proof of identity. **We come to you.**

Good to Know

- Give copies to your doctors, hospital, and the people you named. Keep the original.
- You may revoke this authorization in writing at any time.
- For health care decisions (not just information), use the Nevada Advance Health-Care Directive.

Need a Notary? We Come to You.

Homes • Hospitals • Care Facilities • Offices • Available Anytime
Mobile notary and apostille services.

Nevada-Commissioned Notaries

SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in Nevada, California, and other states. Phone and video consultations are available. **(916) 504-0529** · **www.gavrilovlaw.com**

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 Nevada attorney. © 2027 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.

YOUR FORM BEGINS ON THE NEXT PAGE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

HIPAA Authorization (45 CFR § 164.508) — Nevada

1. Patient.

_____ _____ _____

(full legal name) (date of birth) (phone)

_____

(address, city, state, ZIP)

2. Who may release my information: ☐ all of my health care providers, health plans, and insurers ☐ only:

_____

(name of provider, hospital, or plan)

3. Who may receive my information (my personal representatives for these purposes):

Name	Relationship	Phone / email

4. Information covered: ☐ all of my health information, including records of diagnosis, treatment, billing, and payment ☐ only the following:

_____

(describe)

Unless I mark here ☐, this authorization includes information about mental health, substance use disorder, HIV/AIDS, and genetic testing, to the extent permitted by law. (Psychotherapy notes require a separate authorization.)

5. Purpose: ☐ at my request ☐ to assist with my care, bills, and insurance ☐ other:

_____

(describe)

6. Expiration. This authorization expires on (date or event):

_____

(e.g., a specific date, “one year from signing,” or “upon my death”)

7. My rights. (a) I may revoke this authorization at any time by giving written notice to the provider or plan, except to the extent action has already been taken in reliance on it. (b) My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. (c) Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy rules. (d) I may receive a copy of this authorization.

Signed on _____ , at _____

(date) (city and state)

_____ _____

(signature of patient or personal representative) (printed name)

_____

If signed by a personal representative: name and authority (e.g., agent under health care directive, guardian)

Sign in front of the notary public, who will complete the acknowledgment on the next page.

© 2027 First Choice Mobile Notary & Apostille • Serving Nevada • (866) 828-6856 • firstchoicemobilenotary.com

CERTIFICATE OF ACKNOWLEDGMENT

(Nevada Revised Statutes Section 240.166)

State of Nevada)

County of _____)

This instrument was acknowledged before me on _____ by

(date)

_____ .

(name(s) of person(s))

_____

(Signature of notarial officer)

_____

(Title and rank (optional))

(Seal, if any)

© 2027 First Choice Mobile Notary & Apostille • Serving Nevada • (866) 828-6856 • firstchoicemobilenotary.com