FIRST CHOICE
MOBILE NOTARY & APOSTILLE

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

How to Complete Your North Carolina HIPAA Authorization

Authorization for Release of 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. Federal privacy law (HIPAA) limits who doctors, hospitals, and insurers can talk to about you. This authorization lets the people you name receive your health information so they can help you.

1. **Who and what (Page 1)**
   Name the people who may receive your information and choose what may be released. Initial any specially protected records you want included.
2. **Sign before a notary (Page 2)**
   Hospitals and insurers are more likely to accept a notarized authorization without question. Bring a current, government-issued photo ID.

After It's Signed

- Give copies to the people you named and to your doctors and health plans.
- This form works best with a North Carolina Health Care Power of Attorney. We have a free form.

Need a Notary? We Come to You.

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

North Carolina-Commissioned Notaries

SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in multiple states. Phone and video consultations are available, wherever you are. **(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 North Carolina 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

HIPAA AUTHORIZATION

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

1. PATIENT

Full legal name

Date of birth

Address

Telephone

2. WHO MAY RELEASE INFORMATION. Every physician, hospital, clinic, laboratory, pharmacy, therapist, health plan, insurer, and other covered entity that has provided treatment, services, or payment to me.

3. WHO MAY RECEIVE INFORMATION

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

4. INFORMATION TO BE RELEASED (check one)

All of my health information, including records, test results, diagnoses, treatment, billing, and payment records.

Only the following:

Unless I initial below, this authorization does not include psychotherapy notes or the following specially protected records. I separately authorize release of (initial each):

☐ Mental health records (other than psychotherapy notes)

☐ HIV/AIDS and other communicable disease information

☐ Substance use disorder treatment records

☐ Genetic testing information

Patient's initials: _____

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

5. PURPOSE. At my request, to allow the persons named to discuss my care with my providers and assist with my health care and insurance matters.

6. EXPIRATION (check one)

Two years after my death.

On the following date or event:

Date or event

7. MY RIGHTS. I may revoke this authorization in writing at any time, except for action already taken in reliance on it. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing it. Information disclosed may be redisclosed by the recipient and may no longer be protected by federal privacy rules. A copy is as valid as the original. My agents under any medical durable power of attorney are to be treated as my personal representatives.

Date

X

Signature of patient (or personal representative)

Printed name

NOTARY ACKNOWLEDGMENT

STATE OF NORTH CAROLINA)
)
COUNTY OF)

I certify that the following person(s) personally appeared before me this day, each acknowledging to me that he or she signed the foregoing document:

name(s) of signer

Date

X

Notary Public

(Notary seal)

Notary's printed name

Notary Public, County of commission

My commission expires

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