Marius Maxwell, MD, PhD, FACS, FAANS
Board Certified Neurosurgeon
1335 Gambell St, Suite 200 | Anchorage, AK 99501 | P: (907) 222-6500 | F: (907) 222-6550

Authorization for the Use or Disclosure of Protected Health Information

I, ____ *(Patient First Name, Last Name)* Date of Birth: ____________________________

hereby give permission to release my health information as identified below:

From:

Facility / Clinic	Health information requested

To: ____

For the purpose of:

- ☐ At the request of the individual
- ☐ Continual care
- ☐ Legal
- ☐ Insurance
- ☐ Other: ____

This authorization shall not be valid greater than ***one*** *year from date of signature.*

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sing this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of the protected health information.

____ ____ ____________________

Print Name Signature Date

Confidentiality Notice: Privileged/confidential information may be contained in this message. The information contained in this message is intended only for the use of the recipient and colleagues working on the same matter. The recipient of this information is prohibited from disclosing the information to any other party unless this disclosure has been authorized in advance. If you are not the intended recipient, please notify the sender immediately at the fax number listed above and destroy any and all copies of the original message.