TARIQ HASSAN MD
Gastroenterology
2870 NETHERTON DRIVE ST LOUIS MO 63136

Authorization for Release of Medical Information Date ___________

Patient Name _______________________________ Date of Birth ____________________________

Social Security Number (Last 4 numbers) ____ ____ ____ ____

Contact number ____

I authorize the use or disclosure of the above-named individual's health information as described below.

INFORMATION TO BE RELEASED BY: Esse Digestive Disease Specialists 100 Village Square, MO, 63042 Phone 314 355 4010 Fax 314 355 9484

INFORMATION TO BE RELEASED TO:

Tariq Hassan MD 2870 Netherton Drive, St Louis, MO, 63136 Fax Number: 314 529 0687

TYPE OF MEDICAL INFORMATION TO BE DISCLOSED WILL BE :

Colonoscopy ,EGD/ERCP reports, Pathology reports, Radiology Reports/CT Scans/US, MRI, Office Notes, Dates of Treatment: Last 5 years

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing or treatment; unless specifically excluded____I understand I have a right to cancel this authorization at any time. I understand if I wish to withdraw this authorization, I must do so in writing. I must present my written cancellation to the health information management department. I understand the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date or event ______________________________. If I fail to specify an expiration date or event, this authorization will expire in six months. I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager

Signed __________________________Printed Name _________________________Date ____________

Phone 314 529 0661, Fax 314 529 0687, Web site colonage50.com, email colonage50@gmail.com, Exchange 314 591 4866