HerMD

Medical Records Request Form

1. Please enter the patient's information.

   Patient Full Name _____

   Date of Birth (Month/Day/Year) _____

   Street Address _____

   Apt/Unit # _____

   City _____

   State _____

   Zip Code _____

   Mobile Phone _____

   Email _____

   Preferred contact method

   Mobile Phone Email

Release of Medical Records

The above named person is or has been a patient of Her M.D., Inc., Somi Javaid MD & Associates, LLC and / or their affiliates, with locations at:

HerMD Cincinnati	HerMD Carmel	HerMD Franklin	HerMD Millburn
8350 E Kemper Road, Suite A Cincinnati, OH 45249 (P) 513-404-4166	885 Monon Green Blvd, Suite 118 Carmel, IN 46032 (P) 463-333-9955	7020 Berry Farms Crossing, Suite 100 Franklin, TN 37064 (P) 629-230-9252	241 Millburn Ave Suite 1 Millburn, NJ 07041 (P) 862 289- 6590

2. The above named person authorizes Her M.D., Inc., Somi Javaid MD & Associates, LLC and / or their affiliates to release medical records and protected health information to:

   Name of Individual, Medical Provider or Hospital:

   _____

   Street Address _____

   Apt/Unit # _____

   City _____

   State _____

   Zip Code _____

   Fax Number _____

3. The purpose of this medical records request is for:

   Self Continuity of Care Disability Legal Insurance

   Research Other

   The scope of this medical records release shall be:

   All information regarding assessment, diagnosis and treatment of patient's condition, concern or disease (please specify below)

   All information regarding care received by patient during a specific period of time (please specify below)

   Other (please specify below)

   If other, please specify: _____

   This authorization shall expire on:

   The date when information is received / delivered The six-month anniversary of the authorization

   The one-year anniversary of the authorization The three-year anniversary of the authorization

Sensitive Information: I understand that the information in my records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I

revoke this authorization, I must do so in writing via mailing or fax to Somi Javaid MD & Associates, LLC. I understand that revocation will not apply to information that has already been released based on this authorization

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. Research participation requires a separate authorization by the patient. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions about disclosure of my health information, I can contact Somi Javaid MD & Associates, LLC at the phone number provided above.

Once complete, please email to: questions@hermdhealth.com

Patient or Responsible Party Signature

Date