Dorin Kemmerle, MD LLC dba Sprout Pediatrics
4350 Commercial St SE, Salem, OR 97302
(503) 877-4485 (888) 977-1263
SproutPediatrics.com

Authorization for Release of Medical Information TO Sprout Pediatrics

Child's name: ____ Date of birth: ____/____/____

Additional children for whom this release applies: ☐ Not applicable

Child's name: ____ Date of birth: ____/____/____

Child's name: ____ Date of birth: ____/____/____

Child's name: ____ Date of birth: ____/____/____

Child's name: ____ Date of birth: ____/____/____

I request to have the medical records for the above named child(ren) be released from

Childhood Health Associates of Salem
891 23rd Street NE
Salem OR 97301
Telephone: (503) 364-2181
Fax: (503) 364-0364

To: **Sprout Pediatrics, 4350 Commercial St SE, Salem OR 97302**
Phone: (503) 877-4485 **Fax: (888) 977-1263**

Please release the following:
___ **All health information** (including growth charts and vaccination records)
___ Progress Notes ___ Diagnostic Test Reports
___ Discharge Summary ___ Radiology Reports & Images
___ Other (specify): ____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records
___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure: Treatment / Continuing medical care

This authorization is valid until I revoke it in writing.

____ _____________________________
Patient/Responsible Party Signature Date

____ _____________________________
Patient/Responsible Printed Name Relationship to patient(s)