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) released from

Salem Hospital
Health Information Management
890 Oak St SE
Salem OR 97301
Telephone: (503) 561-5750
Fax: (503) 814-2728

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**
☐ Rehabilitation Evaluations & Notes
☐ Discharge Summaries
☐ Date(s) of Service: _____
☐ Outpatient Records
☐ Emergency & Urgent Care Records
☐ Diagnostic Test Reports
☐ Radiology Reports & Images

I consent ☐ / do not consent ☐ to the release of information related to genetic testing, HIV/AIDS or other communicable diseases, behavioral or mental health services, and treatment for alcohol and drug abuse.

Purpose of disclosure: Treatment / Continuing medical care
Preferred format: CD with PDFs

This authorization is valid until I revoke it in writing.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Patient/Responsible Printed Name Relationship to patient(s)