



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: ___/___/___

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

Salem Pediatric Clinic
2478 13th Street SE
Salem OR 97302
Telephone: (503) 362-2481
Fax: (503) 371-7803

**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)