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 Clinic
2020 Capitol Street NE
Salem OR 97303
Telephone: (503) 399-2424
Fax: (503) 361-3780

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 ☐ / 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

This authorization is valid until I revoke it in writing.

_____ _____
Patient/Responsible Party Signature Date

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