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

Provider:_____

Address: _____

_____

Phone: _____ Fax: _____

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)