Dorin Kemmerle, MD LLC dba Sprout Pediatrics
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(503) 877-4485 (888) 977-1263
SproutPediatrics.com

Authorization for Sprout Pediatrics to Release Medical Information

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 Sprout Pediatrics to release medical information for the above named child(ren) to:

Provider:_____

Address: _____

_____

Phone: _____ Fax: _____

Please initial the information you consent to release:

____**All health information** (including growth charts and vaccination records)

____Office Visit Notes ____Diagnostic Test Results

____Growth Charts ____Consultation Reports

____Immunization Records ____Other _____

If the information to be disclosed contains any of the information listed below, additional laws relating to the use and disclosure of the information may apply. I am indicating my agreement to the disclosure of this information with my initials below.

____Mental Health (including ADHD/ADD) (parent if patient under age 14, patient if over 14)

____Alcohol/Chemical Dependency (parent if patient under age 14, patient if over 14)

____Sexually Transmitted Diseases, (patient only)

____Birth Control (patient only)

____Genetic Information (parent if patient under age 14, patient if over 14)

____HIV/AIDS (parent if patient under age 14, patient if over 14)

Please release information from: ☐ entire duration of record ☐ prior year ☐ prior two years

☐ specific dates: _____

I understand that this authorization shall remain in force until I revoke it in writing. I also understand that any use or disclosure already made with my permission cannot be undone, and that the information used or disclosed may be subject to re-disclosure by the recipient and no longer protected under federal law.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Patient/Responsible Printed Name Relationship to patient(s)