

DISCLOSURE POLICY

I authorize S.M.I.L.E.S., Inc. to release all pertinent information regarding my child's or my evaluation and/or treatment information to the individual (s), company, or group stated below. I understand that to discontinue authorization, I need to submit a request in writing.

Name _____
Date

Address

Fax number _____
Phone number

Name _____
Date

Address

Fax number _____
Phone number

Name _____
Date

Address

Fax number _____
Phone number

Guardian _____
Date

Witness _____
Date

