Disclosure Policy

I, ___________________, ___________________'s caregiver 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	
______________________ Street Address	______________________ eMail Address
______________________ City, State, Zip code	
______________________ Phone	______________________ Fax

______________________ Name	
______________________ Street Address	______________________ eMail Address
______________________ City, State, Zip code	
______________________ Phone	______________________ Fax

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513.404.5915

Name	
Street Address	eMail Address
City, State, Zip code	
Phone	Fax

Name	
Street Address	eMail Address
City, State, Zip code	
Phone	Fax

Patient's Name	
Caregiver's Name	Date
Witness	Date