Disclosure Policy

I, _____, _____'s caregiver authorize S.M.I.L.E.S., Integrative Therapy Services, LLC 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

S.M.I.L.E.S. Integrative Therapy Services, LLC
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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