



(Print name of patient)

 $\frac{\text{PATIENT INFORMATION}}{\text{I hereby authorize Your Smile, to release the information from the dental record(s) of:} \\$

(Relationship to patient) Date: Witness) PAYMENT METHOD Cash Master Card/Visa/Discover* (Relationship to patient) (Relationship to patient) Date: Patient, Parent, or Legal Representative) Date: Patient, Parent, or Legal Representative) Date: Your Service of the patient	immune Deficie	ency Syndrome (AID					ency Virus (HIV) and/or Acquire ested to be omitted.
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