



Great Lakes Center for Autism Treatment and Research
Authorization for Drop Off/Pickup and Permission to Observe

Patient

Date of Birth

Account Number

The following people are authorized to pick up/drop off:

NAME:	RELATIONSHIP TO CHILD:	PHONE NUMBER:
NAME:	RELATIONSHIP TO CHILD:	PHONE NUMBER:
NAME:	RELATIONSHIP TO CHILD:	PHONE NUMBER:

The following people are authorized to observe my child and ask questions to the BCBA:

NAME:	RELATIONSHIP TO CHILD:	PHONE NUMBER:
NAME:	RELATIONSHIP TO CHILD:	PHONE NUMBER:
NAME:	RELATIONSHIP TO CHILD:	PHONE NUMBER:

Name of Parent/Legal Guardian (Please print)

Signature of Parent/Legal Guardian

Date

Witness

Date

