Great Lakes Center for
Autism Treatment and Research
an roi program

Client name____ Date of birth _________________

Case #____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have received a copy of The Great Lakes Center for Autism Treatment and Research/Residential Opportunities Inc.'s Notice of Privacy Practices form.

____ _______________________

Signature of Patient or Authorized Representative Date

____ _______________________

Witness Date