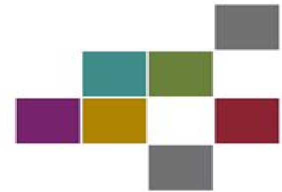
Great Lakes Center for
Autism Treatment
and Research
an roi program



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

The following people are authorized to observe my child during their sessions and ask questions about my child's treatment and services to the clinician:

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