Central Arkansas Pediatric Clinic
Authorization for Alternate Consent

I, _____, the (mother, father, legal guardian) of _____ (child's name). By signing below, I hereby authorize **Central Arkansas Pediatric Clinic** to provide medical services to my child as deemed necessary by the physicians at Central Arkansas Pediatric Clinic upon obtaining the written consent of any one of the following individuals:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

I agree to pay for the charges billed for any and all services provided to my child by Central Arkansas Pediatric Clinic based upon the consent of any one of the above-named individuals.

I understand and agree that this Authorization will remain in effect until I revoke this Authorization by delivered written notice of such revocation to Central Arkansas Pediatric Clinic.

_____
Signature

_____
Printed Name

_____
Date

_____
Central Arkansas Pediatric Clinic Employee
Witness of Signature