Alliance Pediatrics, P.A.
Authorization for Alternate Consent

I, ________________________________, the (mother, father, legal guardian) of ______________________________ (child's name). By signing below, I hereby authorize **Alliance Pediatrics, P.A.** to provide medical services to my child as deemed necessary by the physicians at **Alliance Pediatrics, P.A.** 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 **Alliance Pediatrics, P.A.** 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 **Alliance Pediatrics, P.A.**

____

Signature

____
Printed Name

____
Date

____
Alliance Pediatrics, P.A. Employee
Witness of Signature