**Consent to treat a minor**

**Patient Name:**

**DOB:**

***I (or my legal guardian or parent) authorize Soliman care Family practice Inc to provide medical care reasonable by today’s standards.***

***Legal Gurdian Name:***

***Phone Number:***

***Signature of Patient/Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***