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Child, Adolescent and Adult Psychiatry

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Geriatric and Adult Psychiatry

I, (*print*) _____, As Parent/Guardian, cannot be present at the
Evaluation/Follow-up of my child (*print*) _____, but give
permission for all of the following that I initial to take place at Dr. Murko's office,

- 1. Outpatient evaluation and treatment (initial) _____
- 2. Referral to other Physicians (initial) _____
- 3. Regular return visits for treatment (initial) _____
- 4. Dispensing of psychotropic medication (initial) _____

The parent not accompanying the child to the appointment must include a copy of driver's license or state I.D or get this form notarized.

(*Print name*)

(*Contact phone number*)

(*Signature*)

(*Relationship to patient*)

(*Date*)

Meeting mental health needs in South Florida communities – one family at a time