

Aida M. Murko, M.D., P.A.

*Diplomate, American Board of Psychiatry and Neurology
Child, Adolescent and Adult Psychiatry*

Zoran Murko, M.D., P.A.

Geriatric and Adult Psychiatry

Date: _____

I, _____ certify that I am the Parent /Guardian and the sole person authorized to make medical and psychiatric decisions regarding the treatment of (Child/minor's name) _____. This includes referrals to other Doctors, Psychologists, Neuropsychological testing, therapy, and any medications Dr. Murko deems necessary for the treatment of (child/minor's name) _____.

Print name of child/minor

Print name of Parent/Guardian

Signature of Parent/Guardian

Date

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