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**ULTRASOUND AUTHORIZATION**

Name: \_\_\_\_\_

Is authorized to have

1 \_\_\_\_\_

2 \_\_\_\_\_

Please check # of authorized ultrasounds

Doctor Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_