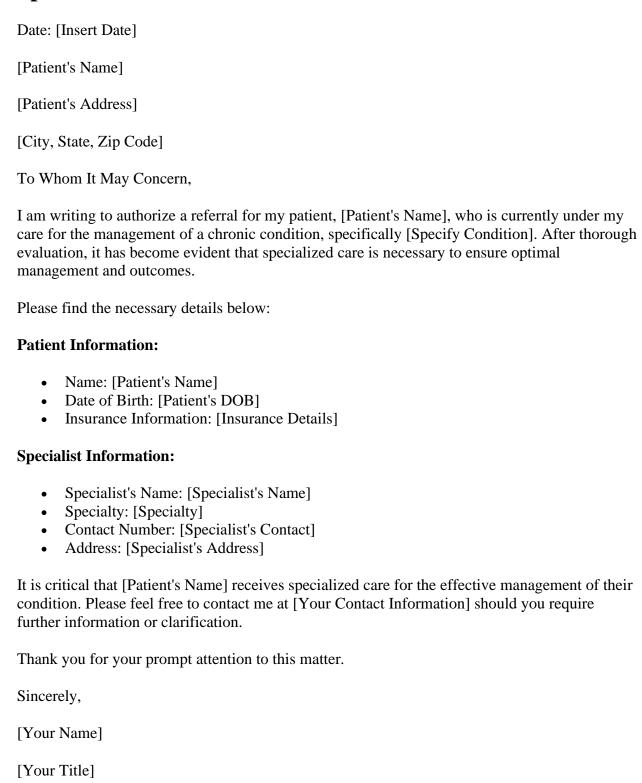
## **Specialist Referral Authorization**

[Your Practice/Clinic Name]



[Your Address]

[City, State, Zip Code]

[Your Phone Number]