

**Credit Card Authorization Form**

Please complete all fields. You may cancel this authorization at any time by contacting me. This authorization will remain in effect until cancelled.

**Credit Card Information**

Card Type:  MasterCard     VISA     Discover     AMEX     Other \_\_\_\_\_

Cardholder Name (as shown on card): \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date (mm/yy): \_\_\_\_\_ cvv code: \_\_\_\_\_

Cardholder ZIP Code (from credit card billing address): \_\_\_\_\_

Cardholder email address: \_\_\_\_\_

I, \_\_\_\_\_, authorize *Dr. A. Robin Aylor* to charge my credit card above for agreed upon payments. I understand that my information will be saved to file for future transactions on my account.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date

Please check this box if you prefer not to have your receipts sent to you by email or SMS