



Credit Card Authorization Form

Please complete all fields. Attach a copy of your credit card and ID. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover	<input type="checkbox"/> AMEX
	<input type="checkbox"/> Other _____			
Cardholder Name (as shown on card): _____				
Card Number: _____				
Expiration Date (mm/yy): _____				
Cardholder ZIP Code (from credit card billing address): _____				

I, _____, authorize Hillcrest Pharmacy to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date