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## Credit Card Authorization Form

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Name:  Date:

Company Name:

Phone Number:  Fax Number:

Email:

Cardholder Name:

Card Type: Mastercard:  Visa:

Credit Card Number:  -  -  -

Card Billing Address:

Street Address

City  Province  Postal Code

Expiry Date:

CVV:

(the last three digits on the back)

RX Compounding Pharmacy is hereby authorized to accept orders from individual/business indicated above, charge the cost this/these order(s) to the credit card account and ship the merchandise as requested. By signing this document, I/we accept full responsibility for these transactions and ensure full payment to RX Compounding Pharmacy. I will inform RX Compounding Pharmacy immediately if use of this card is no longer authorized.

SIGNATURE: