Credit Card Authorization Form

Patient Name: ____

Fee amount: $14.85

PLEASE PRINT

CARDHOLDER INFORMATION

Name:____

Billing Street Address:____

Street Address (cont.):____

City:_______________________ State:___________ Postal Code:___________________

Country:______________________________Email ______________________________

Address:____

Direct Telephone: (_____)______-__________

CREDIT CARD INFORMATION

Credit Card Type: ◻ MasterCard ◻ Visa ◻ American Express ◻ Discover Card

Number:____

Expiration Month:_______Expiration Year:_______

Cardholder Signature X________________________________Date_____/_____/_________

Security Code:________________

Please allow 7-15 business days to receive medical records

Fax the following:

credit card authorization
medical record authorization
photo ID

To: (972) 394-2351 **or mail to**: VitalChart | 120 South Briery | Irving, TX 75060