Phone (888) 392-1234 Fax (727) 584-9602

Authorization to Charge Credit Card

Please fill out this form completely. Please return it to us via fax. Please PRINT CLEARLY in blue or black ink.

CREDIT CARD INFORMATION

____
NAME AS IT APPEARS ON CREDIT CARD

____
STREET ADDRESS

____
APT/UNIT/PO BOX

____
CITY STATE ZIP+4

Total Amount Due: $ __________

Please charge to the following credit card:

___ MasterCard ___ Visa ___Discover ___American Express

Expiration Date: *(Month)* ___ *(Year)* __ 3-Digit Security Code __ __ __found on back signature panel OR 4-Digit Security Code __ __ __ __ found on front of American Express

Credit Card No. ___|___|___|___ - ___|___|___|___ - ___|___|___|___ - ___|___|___|___

I authorize MedRx, Inc. to charge my credit card.

______________________________ ______________________
Cardholder's Signature *Date*

(Optional): As the credit card holder, I also authorize MedRx, Inc. to charge my credit card for future purchases verbally approved by me.

Authorized Signature____

If there is a problem processing this payment, we would like to be able to reach you by phone.

Daytime telephone number: (___|___|___) ___|___|___ - ___|___|___|___

Returned items must have return authorization from MedRx. A 15% restocking fee will apply.
Items may not be returned after 15 days.

Updated 07/25/2013