# Credit Card Authorization Form

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

| Credit Card Information |
|---|
| Card Type: ◻ Visa ◻ Discover ◻ Amex ◻ Other___________________________________ |
| Cardholder Name(as shown on card):____________________________________________________ |
| Card Number and Security Code:__________________________________________ Code:_________________ |
| Expiration Date(mm/yy):_______________________________________ |
| Cardholder ZIP Code(from credit card billing address):_______________________________________________ |

I,_______________________________, authorize **Healthy Perspectives Inc** to charge my credit card above for agreed upon purchases/services. I understand that my information will be saved to a file for future transactions on my account.

_____________________________________________ _______________________________________

Customer Signature Date