

CREDIT CARD AUTHORIZATION FORM

Instructions

1. Complete the form by printing legibly with a dark pen, all billing information in the blanks below.
2. Sign with the credit card holder's signature on the line indicated.
3. Fax this form to our *secure fax machine* at **866-249-9083** to complete your order.

I, _____ (Cardholder's Name)
(printed), hereby authorize Olympia Pharmacy to
charge my credit card account in the amount of \$ _____
Type of Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER
Credit Card Number _____
Expiration Date _____ CVV Code (3 Digits VISA/MC/DISC, 4 digits AmEx) _____

Credit Card Billing Address:

Street: _____
City: _____
State: _____ Zip Code: _____
Telephone: _____

CVV Code Instructions

Visa / MasterCard / Discover -
last 3 digits of the number on the
back of the card.

American Express - 4 digit
number on the front right side of
the card above the credit card
number.

As the credit card holder, I hereby authorize Olympia Pharmacy to charge my credit card account for the amount listed above. I clearly understand that all payments are final and non-refundable.

Cardholder's Signature _____
Date _____

Your completion of this authorization form helps us to protect you, our valued customers from credit card fraud. All information entered on this form will be kept strictly confidential by Olympia Pharmacy

Complete and fax all documents required to: 866-249-9083