

Credit Card Authorization Form

Please complete all 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:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card): _____	
Card Number: _____	
Expiration Date (mm/yy): _____	CVV _____
Cardholder ZIP Code (from credit card billing address) : _____	

I, _____, authorize *Connecticut Behavioral Health* to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date

Note: By typing your name your are digitally signing this document.