

CREDIT CARD AUTHORIZATION

**PLEASE COMPLETE & FAX THIS FORM TO:
310 829-5942**

I, _____, **HEREBY**
COMPANY NAME & CUSTOMER NAME

AUTHORIZE LAUREN SWERDLOFF, MD INC TO CHARGE MY CREDIT

CARD FOR THE EXACT AMOUNT OF \$_____ . THIS PAYMENT WILL BE

APPLIED TOWARD THE PURCHASE OF THE FOLLOWING :

TYPE OF CARD: MASTERCARD_____ VISA_____ AMERICAN EXPRESS_____ DISCOVER

CREDIT CARD #_____ _____ **CIN #** _____

EXPIRATION DATE:_____ (last 3 digits from the back of the card)

NAME ON CARD:_____
PRINT YOUR NAME

BILLING ADDRESS/ZIP OF CARD _____

AUTHORIZATION SIGNATURE:_____

**BOTH CUSTOMER AND COMPANY AGREE THAT A SIGNED FACSIMILLE
IS AS ACCEPTABLE AS A SIGNED ORIGINAL.**

The undersigned hereby declares that the credit information listed above is true, accurate and appears in the name as stated and authorization is hereby given to the above named individuals to use these cards for purchases from Lauren Swerdloff, MD INC.