Breath of Life
Women's Health
& Birth Center

Monthly Credit Card Authorization Form

Name of Card Holder ____

Address: ____ Apt: ____________

City, State, Zip: ____

Phone: (______) ____________ Email: _________________________________

Card Number: _________________________________ Expiration Date: ____/____

Card Type: ❑ ❑ ❑ V-Code: _______________
Check one (the 3 digit code on the back of the card)

Please start: ___________/20____
Month/Year

Monthly Amount: $ ____________

I hereby authorize Breath of Life to deduct the requested amount on a monthly basis from the above credit card. I understand that this will continue until I request otherwise.

Signature: ____________________________ Date: ____/____/____

If you have any questions, please contact Glenda at 727-216-1421 ext. 2

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