Maryland Department of Health and Mental Hygiene
Laboratories Administration

Credit Card Authorization Form One-Time & Repeat Payments

CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

Street Address (cont.):_____

City:_____ State:_____ Postal Code:_____

Country:_____ Email _____

Direct Telephone: _____

Payment Information

Invoice # _____

Customer Code _____

□ I authorize a one-time charge against my credit card for the following amount $_____

□ I authorize the use of this card for future payments

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ VISA

Number:_____

Expiration Month:_____ Expiration Year:_____ CVV (last 3 digits back of card) _____

Cardholder Signature:_____ Date___/___/___

Please fax form with COPY of INVOICE to: Nicole McDonald @ 443-681-5198
Or Mail: DHMH Laboratories Administration, Nicole McDonald, P.O. Box 2355, Baltimore, MD 21203.