Credit Card Authorization Form

Allele Diagnostics
120 N. Pine St, Suite 152
Spokane, WA 99202
Phone: 844-ALLELE2 (255-3532)
Fax: 509-232-5779
Email: info@allelediagnostics.com

Please sign and complete this form to authorize Allele Diagnostics to make a one-time debit to your credit card listed below. By signing this form you give us permission to debit your account for the amount required for the testing performed. If you have any questions regarding this, contact our laboratory at 844-ALLELE2 (255-3532) to discuss. Allele Diagnostics requests this form be completed and sent with the specimen for testing. If the form is completed after the specimen is sent, please send the completed form via fax at 509-232-5779 or via email at info@allelediagnostics.com.

Cardholder Information

Full Name: _____

Billing Street Address: _____

City: _____ State: _____

Postal Code: _____ Country: _____

Telephone: _____ Email: _____

Credit Card Information

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: _____

Expiration Month: _____ Expiration Year: _____ Security Code: _____

Authorized Signature for Credit Card Payment

Credit Card Holder: By signing this form, I request and authorize Allele Diagnostics to charge the credit card listed above.

Signature: _____ **Date:** _____

Signature of Credit Card Holder