Public Health
Prevent. Promote. Protect.
Harford County Health Department

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Credit Card Payment Authorization Form

Sign and complete this form to authorize **Harford County Health Department** to make a one-time charge to your credit card listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I _____ authorize ***Harford County Health Department*** to
(Cardholder's Full Name)

charge my credit card account indicated below for $_____ on _____.
(Amount) (Date)

This payment is for _____.
(Application Type)

Billing Information:

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Cardholder Name _____

Credit Card Number _____

Expiration Date ____/____ CVV _____ Billing Zip Code _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the application described above, for the amount indicated above only, and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature _____ Date _____
(Cardholder)