



Credit Card Authorization

I authorize DNA Health Institute, Cryogenic Division to charge my:
(circle one)

AMERICAN EXPRESS

VISA

MASTERCARD

Credit card number: _____ - _____ - _____ - _____

Exp. Date: _____

CID # _____ (found on back of card, NOT the last four digits of the card number)

Print name as it appears on the credit card: _____

Signature: _____

DATE: _____

Contact Phone: _____

Email Address: _____

Website: _____

Persons authorized to order on this credit card:

1. _____

2. _____

3. _____

This authorization will remain in effect for one calendar year, or until the listed credit card expires, whichever event occurs first. Please contact DNA Health Institute, Cryogenic Division for changes in credit cards, expiration dates, or authorized ordering personnel. This authorization may be revoked at anytime by sending in a letter to that effect to DNA Health Institute, Cryogenic Institute at the address listed below.