THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center

CREDIT CARD CHARGE AUTHORIZATION

I,_____, AUTHORIZE THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER, REVERSE PHASE PROTEIN ARRAY (RPPA) CORE TO CHARGE MY **VISA / MASTERCARD / AMEX** IN THE AMOUNT OF $ _____.

FOR: _____

CARD #: _____

EXP. DATE: _____ SEC. CODE:_____

AUTHORIZED CARD HOLDER:

_____

PRINT

AUTHORIZED CARD HOLDER:

_____

SIGNATURE

DATE:_____

CARD HOLDER'S CONTACT **PHONE:** _____

CARD HOLDER'S CONTACT **EMAIL:** _____

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FOR M.D. ANDERSON USE ONLY:
CO/CTR/ACCOUNT:

Please contact Kathryn Aziz with any questions and to return this form to ccsgrppa@mdanderson.org.