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## PAYMENT AUTHORIZATION FORM

Name on Card: \_\_\_\_\_ Card Type: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

I authorize The Hospital for Sick Children to deduct the following amount from my credit card:

Amount: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_