

**Publix Pharmacy Direct Care**  
Credit Card Authorization Form

**Publix Pharmacy Direct Care  
P.O. Box 147  
Lakeland, Florida 33802-0147  
800-PUBLIX-RX**

**I authorize Publix Super Markets to charge my credit card as  
necessary for prescription services provided to:**

Customer Name

Name On Card

Billing Address

<b>CREDIT CARD NUMBER</b>											
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>EXPIRATION DATE</b>				<b>CREDIT CARD TYPE (check one)</b>							
<input type="text"/>				VISA <input type="checkbox"/>		MASTERCARD <input type="checkbox"/>		DISCOVER <input type="checkbox"/>			

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

