



**AUTHORIZATION AGREEMENT
DIRECT AUTOMATIC MONTHLY PAYMENT
VIA BANK DRAFT (EFT)**

We _____ (CUSTOMER NAME) authorize GLOBAL SOURCE RX, INC. to electronically debit our BANK ACCOUNT indicated below. We authorize our bank account to be debited the (10th) of each month for the prior month's Statement Balance.

Practice Address: _____

City: _____ ST: _____ Zip: _____

Account Holder Name: _____

Bank/Financial Institution Name: _____

Bank Account Type: Checking Savings

Account Number: _____ Routing Number: _____

Bank/Financial Institution Address: _____

City: _____ ST: _____ Zip: _____

Email Address (for billing receipts): _____

Specify min-max range of acceptable dollar amounts authorized: _____

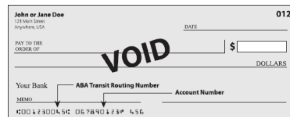
I understand that this authorization is to remain in full force and effect until I notify GLOBAL SOURCE RX, INC. in writing at Global Source RX, Inc., (14505 N Hayden Rd, Scottsdale, AZ 85260) that I wish to revoke this authorization. I understand that GLOBAL SOURCE RX, INC. requires at least five (5) days prior notice in order to cancel this authorization.

NAME: _____ SIGNATURE: _____

JOINT ACCOUNT HOLDER (must sign if applicable)

NAME: _____ SIGNATURE: _____

Please attach an original, voided, bank account check:



Email this form to: accounting@gsrx.com