



Information Delivery & Data Recovery Services Information Form

Completion of this form is required for service.

164 East 14th Street,
Elmira Heights, NY 14903
Phone: (607).733.2902
Email: info@id-dr.com
Web Site: www.id-dr.com



ID-Dr. Credit Card Authorization Form

I, _____, authorize Information Delivery & Data Recovery Services to
Cardholder Name

Charge \$ _____ to my credit card.
Dollar Amount

The cardholder acknowledges receipt of goods and /or services in the amount of the total shown hereon and agrees to perform the obligations set forth in the cardholder's agreement with the issuer.

Cardholder's Signature Date

Credit Card Type (check box). American Express Master Card Visa

Credit Card Number: _____ Expiration Date: _____

Full Name: (as appears on the card): _____

Company Name (if applicable): _____

Mailing Address: _____

Phone: _____

Fax: _____

Office Use Only Authorization #: _____