Credit/Debit Authorization Form

I (we) hereby authorize Rankin County Hospital District (THE COMPANY) to initiate entries to my checking/savings accounts at the financial institution listed below (THE FINANCIAL INSTITUTION), and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until THE COMPANY is notified by me (us) in writing to cancel it in such time as to afford THE COMPANY and THE FINANCIAL INSTITUTION a reasonable opportunity to act on it.

PLEASE PRINT:

_____

(Name)

_____

(Address)

_____

(Name of Financial Institution)

_____

(Financial Institution Routing Number)

_____

(Account Number) Checking ☐ Savings ☐

_____

(Signature) (Date)