DEBIT AUTHORIZATION

I______________________________________hereby authorize Coryell County Memorial Hospital Authority, hereinafter called Coryell Health, to initiate debit entries to my (our) account indicated below and the financial institution named below, hereinafter called (FINANCIAL INSTITUTION), to debit the same such account for (APPLICANT). I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of the U.S. Law.

____ ____________________________
FINANCIAL INSTITUTION NAME **BRANCH**

______________________________ ____________________________ ________________
ADDRESS **CITY/STATE** **ZIP**

____________________ _______________________ Type of Account: Checking Savings
ROUTING NUMBER **ACCOUNT NUMBER**

Amount to debit:____________________. Coryell Health will debit the above account on the 23rd of every month, unless it falls on weekend in which it will be debited on the following business day.

This authority is to remain in full force and effect until Coryell Health has received written notification from me (or either of us) of its termination in such time and manner as to afford Coryell Health and (FINANCIAL INSTITUTION) a reasonable opportunity to act on it.

______________________________ ______________________________
PRINT INDIVIDUAL NAME **SIGNATURE**

______________________________ ______________________________
PRINT INDIVIDUAL ID NUMBER **DATE**

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM

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