One-Time Credit Card Authorization International Resident Maui Health System – Hawaii, USA

Patient Name:			
Maui Health Account Number:			
Total Payment:			
	Credit Card	l Information	
Card Type:	□VISA	□ Discover	□ AMEX
Cardholder Name:			
Card Number:			
Expiration Date (mm/yy):			
authorize Maui Health System to that my information will NOT be s document will be destroyed.			
Signature		ate	
Please mail the completed form to:	<i>A</i> 1 V	Maui Health System ttn: Patient Financial 849 Wili Pa Loop Vailuku, HI 96793	Services

