One-Time Credit Card Authorization

International Resident

Maui Health System (MHS), a Kaiser Foundation Hospitals LLC

Patient Name:				
MHS Account #(s):				
Total Payment:				
Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
Cardholder Name:				
Card #:				
Expiration Date (mm/yy):				

I authorize Maui Health System to charge my credit card for the amount listed above. I understand that my information will NOT be saved for future payments and will be destroyed once processed.

X_____

Signature and Date