Account Balance Automated Billing Authorization Revocation

I _____, wish to revoke the Account Balance Automated Billing Authorization previous signed by me and provided to Uropartners, LLC (**"Uropartners"**) to retain my credit card information on file as part of my personal record for payment purposes only.

I request that my credit card be taken off file, and that no future payments be processed. I understand that I am still responsible for balances that remain due as a result of co-pays, coinsurances, deductibles and benefit maximums after Uropartners receives payment from my insurance company.

Signature of Patient or Patient's Legal Representative: _____Date: _____

Print Name of Legal Representative: _____ Relationship: _____