

REVOCATION OF CREDIT/DEBIT CARD ON FILE AUTHORIZATION

PATIENT INFORMATION

Patient Last Name	First Name	Middle Initial	Date of Birth
_____	_____	_____	_____
Street Address	City	State	Zip
_____	_____	_____	_____
Phone Number	Email Address	Date of Request	
_____	_____	_____	

REVOCATION STATEMENT

I hereby revoke my authorization for **Prime Medical Group, LLC** (dba Gilbert Center for Family Medicine) to store and charge the credit/debit card on file in my account. I understand the following:

- **Scope of Revocation:** This revocation applies to all future charges to the card currently on file in my account under the Card on File Consent Form I previously signed.
- **Effect on Prior Charges:** This revocation does not affect any charges already processed or amounts due that were charged in reliance on my original authorization prior to receipt of this revocation.
- **Outstanding Balances:** I understand that any outstanding patient-responsible balances on my account remain due and payable. I agree to make alternative payment arrangements for any current or future balances by contacting the billing department.
- **Effective Date:** This revocation takes effect upon confirmed receipt by GCFM's billing department. I understand that a charge already in process at the time of receipt may not be reversible.
- **Continued Care:** I understand that revoking this authorization does not affect my right to receive care at Gilbert Center for Family Medicine. A card on file is required for patient-responsible balances under GCFM's billing policy, and I agree to maintain an alternative payment arrangement acceptable to GCFM.

Preferred Alternative Payment Method: ☐ Cash ☐ Check ☐ Money Order ☐ Different Credit/Debit Card
☐ Payment Plan (contact billing)

In Person: Deliver to front desk staff at 652 E. Warner Rd, Suite 107 Gilbert, AZ 85296	By Mail: Prime Medical Group, LLC Attn: Billing Department 652 E. Warner Rd, Suite 107 Gilbert, AZ 85296
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PATIENT SIGNATURE

_____	_____	_____
Patient Signature	Date of Birth	Date

Legal Representative Signature (if applicable)	Relationship to Patient / Authority (e.g., POA, Guardian)	

FOR OFFICE USE ONLY			
Date Received: _____	Received By: _____	Method: ☒ In-Person ☐ Mail ☐ Fax ☐ Portal	
Card Removed from System: ☒ Yes ☐ No	Date: _____	Initials: _____	Patient Notified of Effective Date: ☒ Yes ☐ No Date: _____