Individual Revocation of PHI Authorization

I, _____ (patient's name), am notifying _____ (name) _____ (title) Comprehensive Professional Systems Inc. located at 11 Hanover Square, 8th Floor, New York, NY 10005, that I am revoking my authorization dated _____ (date) for the release of my health information for the assistance in claim administration on my behalf.

I understand that I cannot revoke any action already taken by Comprehensive Professional Systems Inc. in reliance upon my authorization prior to the date of this revocation.

_____ _____

Patient's Signature Date

_____

Print Patient's Name