

# Autopay Cancellation Request

Date: [Insert Date]

To: [Healthcare Provider's Name]

[Healthcare Provider's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request the cancellation of my autopay arrangement for healthcare services. My account details are as follows:

**Patient Name:** [Your Full Name]

**Account Number:** [Your Account Number]

**Service Plan:** [Details of the Service Plan]

Please consider this letter as my official notice to terminate the autopay setup effective immediately or as per the next billing cycle on [insert date]. I understand that any outstanding balances will still be my responsibility and I will arrange for payments accordingly.

Thank you for your prompt attention to this matter. Please confirm the cancellation of my autopay arrangement in writing.

Sincerely,

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]