[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: NOTICE OF DISCHARGE FROM MEDICAL CARE

Dear [Patient Name],

Please be advised that [Clinic Name] and [Provider Name] will no longer be able to serve as your healthcare provider. This decision is effective [30 Days from Date of Letter].

This decision has been made due to continued non-compliance with the established treatment plan, including:
[List specific reasons, e.g., missed appointments, failure to follow medication protocols, or failure to complete required testing].

To ensure your health needs are met, we will provide emergency medical care only for the next 30 days. After [Date], we will no longer provide any medical services to you. We recommend that you find a new physician as soon as possible to ensure continuity of care.

You may contact your insurance provider or the local medical society for a referral to a new practitioner. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider.

Sincerely,

[Provider Signature]
[Provider Name]
[Clinic Name]