

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID: [ID Number]

Medical Clearance Discharge Letter

To Whom It May Concern,

This letter serves to certify that the patient named above has been under the care of [Clinic Name] for the management and treatment of [Condition/Infectious Disease Name].

As of [Date], the patient has completed the required treatment protocol and has undergone clinical evaluation. Based on the most recent laboratory results and clinical assessment, the patient is now considered:

- Non-infectious and no longer poses a risk of transmission to others.
- Cleared to return to [Work / School / Normal Activities] without restrictions.

Follow-up Instructions:

[Insert follow-up instructions or state "No further follow-up required"].

Should you require any further information or verification regarding this discharge, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Clinic Name]

[Clinic Address]