Comfort Care Medical Clinic
123 Wellness Way
City, State, Zip Code
Phone: (555) 012-3456

Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Patient ID: [Insert ID Number]

Subject: Patient Discharge Summary

Dear [Patient Name],

This letter serves as official notification of your discharge from Comfort Care Medical Clinic, effective [Insert Date].

Admission Date: [Insert Date]
Discharge Date: [Insert Date]
Final Diagnosis: [Insert Diagnosis]

Follow-Up Instructions:
[Insert specific instructions, such as diet, activity levels, or wound care].

Medications:
Please continue or start the following medications as prescribed:
- [Medication Name], [Dosage], [Frequency]

Follow-Up Appointment:
Your next appointment is scheduled for [Date] at [Time] with [Provider Name].

If you experience any worsening symptoms or emergencies before your follow-up, please contact our office immediately or visit the nearest emergency room.

Sincerely,

[Physician Signature]
[Physician Printed Name]
Comfort Care Medical Clinic