[Date]

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

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide medical care to you effective [Date - 30 days from letter date]. This decision has been made due to your continued non-compliance with the medical treatment plan and protocols established for your care.

Successful medical treatment requires a collaborative relationship and adherence to recommended follow-up appointments and medication regimens. Unfortunately, the recent lack of cooperation has made it impossible to maintain a standard of care that ensures your safety and well-being.

We will continue to provide emergency medical services for you on a limited basis until [Date]. This 30-day period is intended to allow you sufficient time to establish a relationship with a new physician. We recommend that you contact your health insurance provider or the local medical society to locate a new provider in your area.

Upon receipt of a signed authorization form, we will provide a copy of your medical records to your new physician to ensure a smooth transition of care. You may obtain this form by contacting our office at [Phone Number].

Sincerely,

[Physician Name/Signature]
[Practice Name]