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

[Date]

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

RE: FINAL NOTICE OF DISCHARGE FROM MEDICAL CARE

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide you with medical care. This decision is final and is the result of continued non-compliance with the established treatment plans and practice policies, despite previous notifications.

The physician-patient relationship will officially terminate 30 days from the date of this letter, on [Date]. During this 30-day period, we will only be available to provide you with emergency medical care or to facilitate the transfer of your care to a new provider.

To ensure your health needs are met, we recommend that you locate a new physician as soon as possible. You may contact your insurance provider or the local medical society for a list of available practitioners in your area.

We are happy to transfer a copy of your medical records to your new physician. Please find the enclosed "Authorization to Release Medical Records" form. Complete and return this form to our office so that we may forward your files promptly.

After [Date], we will no longer provide any medical services, prescription refills, or consultations for you.

Sincerely,

[Physician Name/Administrator Name]
[Practice Name]

Enclosure: Medical Records Release Form