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

[Date]

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

Dear [Patient Name],

Please be advised that [Physician Name/Practice Name] will no longer be able to serve as your medical provider effective [Date - typically 30 days from letter date].

This decision has been made because of your continued failure to follow the medical advice and treatment plans provided to you. Specifically, on [Date(s)], we discussed the importance of [mention specific advice, e.g., medication compliance, specialist referrals, or follow-up testing]. Effective medical care requires a collaborative relationship based on mutual trust and adherence to agreed-upon clinical recommendations. Because this partnership is no longer functioning effectively, we can no longer accept responsibility for your care.

We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days, until [Date]. This period is intended to allow you sufficient time to establish care with a new physician.

To assist in your transition, we recommend contacting your insurance provider or the local medical society for a list of available physicians in your area. You may also consider [Name of local hospital/referral service].

We are happy to transfer a copy of your medical records to your new provider once we receive a signed authorization form from you. An authorization form is enclosed for your convenience.

Sincerely,

[Physician Signature]
[Physician Name]
[Practice Name]

Enclosure: Medical Records Release Form