[Date]

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

RE: Notice of Discharge from Sleep Medicine Care

Dear [Patient Name],

This letter is to formally notify you that [Provider Name/Clinic Name] will no longer be able to provide you with sleep medicine services. We are discharging you from our practice effective [Date - typically 30 days from letter date].

This decision has been made due to your continued noncompliance with the recommended treatment plan for [Condition, e.g., Obstructive Sleep Apnea]. Specifically, our records indicate the following:

- [List specific issues, e.g., Failure to use CPAP machine as prescribed]
- [List specific issues, e.g., Multiple missed follow-up appointments]
- [List specific issues, e.g., Failure to complete required diagnostic testing]

Untreated sleep disorders carry significant health risks, including increased risk of hypertension, heart disease, stroke, and motor vehicle accidents due to daytime sleepiness. It is critical for your health that you continue to seek treatment from another sleep specialist.

We will provide emergency care and refills for essential medications related to this specialty for the next 30 days, until [Date]. This should provide you with sufficient time to establish care with a new provider.

To assist in your transition, you may contact your insurance provider for a list of sleep medicine specialists in your network. Upon receipt of a signed authorization form, we will forward your medical records to your new physician.

Sincerely,

[Physician Signature]
[Physician Name]
[Clinic Name]