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

[Date]

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

RE: Notice of Termination of Medical Care

Dear [Patient Name],

This letter is to formally notify you that [Practice Name] will no longer be able to provide you with medical care. This decision is effective as of [Date 30 days from now].

We will remain available to provide you with emergency medical care and necessary prescriptions for the next 30 days, until [Date], to allow you sufficient time to establish care with another provider. After this date, our professional relationship will be officially terminated.

We recommend that you contact your health insurance provider or the local medical society to assist you in finding a new physician. If you require a copy of your medical records, please sign the enclosed authorization form and return it to our office. We will transfer your records to your new physician upon receipt of your written request.

Thank you for the opportunity to have served your healthcare needs in the past. We wish you the best in your future medical care.

Sincerely,

[Doctor Name/Practice Manager Name]
[Title]
[Practice Name]