

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you, effective [Date - typically 30 days from letter date].

This decision has been made due to your continued non-compliance with the medical treatment plan and recommendations discussed during your appointments. Follow-up care and adherence to prescribed treatments are essential for providing safe and effective medical management. Unfortunately, without your cooperation, we can no longer fulfill our professional obligations to you as your healthcare provider.

We will continue to provide care for any emergency medical needs for the next 30 days to allow you sufficient time to establish care with another physician. After [Date], we will no longer be available to treat you or provide prescription refills.

We recommend that you secure a new healthcare provider as soon as possible. You may contact your insurance carrier or the local medical society for a list of available physicians in your area.

Upon receipt of your written authorization, we will transfer a copy of your medical records to your new physician. A medical record release form is enclosed for your convenience.

Sincerely,

[Physician Name/Signature]

[Practice Name]