

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Physician Name or Practice Name] will no longer be able to provide medical care to you effective [Date, typically 30 days from date of letter].

This decision has been made because of a breakdown in the physician-patient relationship. We believe that a relationship of mutual trust and cooperation is essential to providing quality medical care, and unfortunately, that foundation no longer exists.

Until [Date], we will be available to provide care for emergencies only. This notice period is intended to give you sufficient time to locate a new physician. We recommend contacting your health insurance provider or the local medical society for a referral to a new primary care provider.

Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new physician to ensure continuity of care. You may find an authorization form attached to this letter or pick one up at our office.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Practice Name]