

Date: [Insert Date]

To: [Patient Name]

Address: [Patient Address]

City, State, Zip: [Patient City, State, Zip]

RE: FINAL NOTICE AND DISMISSAL FROM MEDICAL CARE

Dear [Patient Name],

Please be advised that [Practice/Clinic Name] is officially terminating the physician-patient relationship with you, effective 30 days from the date of this letter. This decision follows our previous discussions and notifications regarding your persistent failure to follow medical advice and prescribed treatment plans.

As we have discussed on [Dates of Previous Discussions], following a recommended medical regimen is essential for your safety and the successful management of your health. Your continued non-compliance makes it impossible for us to provide you with the standard of care required.

During the next 30 days, until [Insert Date 30 Days from Now], we will remain available to provide you with emergency medical care only and to assist you in transitioning your care to a new provider. After this date, we will no longer provide any medical services to you.

We recommend that you secure a new physician as soon as possible. You may contact your insurance provider or the local medical society for a referral. Upon receipt of a signed authorization form from you, we will transfer a copy of your medical records to your new physician.

A copy of your medical records release form is enclosed for your convenience.

Sincerely,

[Physician Name/Administrator Name]

[Practice Name]

Enclosure: Medical Records Release Form