[Date]

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

Re: Notice of Dismissal from Care

Dear [Patient Name],

This letter is to formally notify you that [Clinic/Provider Name] is terminating the provider-patient relationship, effective [30 Days from Date of Letter].

This decision has been made due to repeated absences from scheduled telehealth appointments. Our records indicate that you have missed appointments on the following dates: [List Dates]. Despite previous warnings regarding our attendance policy, these missed appointments have continued to disrupt the delivery of your care and our clinical operations.

We will continue to provide emergency care and essential prescriptions for the next 30 days, until [Effective Date], to allow you sufficient time to find a new healthcare provider. After this date, we will no longer provide any medical services to you.

We recommend that you contact your insurance provider or use online physician directories to locate a new provider as soon as possible. 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.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Provider Name/Signature]
[Practice Name]