

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

RE: FINAL NOTICE OF DISMISSAL FROM MEDICAL CARE

Dear **[Patient Name]**,

Please be advised that **[Practice Name]** will no longer be able to provide medical services to you effective 30 days from the date of this letter. This decision is a result of continued non-compliance with the treatment plan discussed on **[Date of previous warnings/discussions]**.

To ensure your health and safety, it is essential that you follow the prescribed medical advice and treatment protocols. Because the physician-patient relationship requires mutual cooperation and trust, we can no longer continue your care under the current circumstances.

We will remain available to provide care for emergency situations only until **[Date 30 days from letter]**. This notice period is intended to give you sufficient time to locate a new healthcare provider. We recommend contacting your insurance carrier or a local physician referral service to find a new provider as soon as possible.

Upon 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/Administrator Name]

[Practice Name]

[Phone Number]

Enclosure: Medical Record Release Form