[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: NOTICE OF DISCHARGE FROM MEDICAL CARE

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name/Provider Name] will no longer be able to provide you with medical care, effective [30 Days from Date of Letter].

This decision has been made due to ongoing non-compliance with the treatment plan and clinical recommendations discussed during your appointments. Specifically, [Optional: Insert brief reason such as missed appointments, failure to complete lab work, or non-adherence to medication]. Effective medical treatment requires a collaborative relationship between patient and provider, which we feel is no longer possible.

We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days, until [Final Date], to allow you sufficient time to find a new healthcare provider.

To ensure your continuity of care, we recommend that you contact your health insurance provider or visit the local medical society to find a new physician. Once you have selected a new provider, please sign the enclosed medical record release form and return it to our office. We will transfer your medical records to your new physician promptly.

If you have any questions regarding this transition, please contact our office manager at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name]
[Clinic Name]