[Practice Name]
[Doctor's Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: NOTICE OF TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

Please be advised that [Practice Name] and [Doctor's Name] will no longer be able to serve as your medical provider. This decision has been made effective [Date, minimum 30 days from letter date] due to your continued non-compliance with the prescribed medication regimen and treatment plan discussed during our previous appointments.

Successful medical treatment requires a collaborative effort between the physician and the patient. Persistent failure to follow medication protocols compromises your safety and prevents us from providing the standard of care required for your condition.

We will continue to provide care for emergency situations only for the next 30 days, until [Date]. This grace period is intended to give you sufficient time to locate a new physician. We recommend contacting your insurance provider or the local medical society for a list of available practitioners in your area.

Upon your written authorization, we will transfer a copy of your medical records to your new physician to ensure continuity of care. Please find the enclosed medical record release form for this purpose.

We wish you the best in your future health endeavors.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Practice Name]