

[Current Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] is terminating the physician-patient relationship with you, effective 30 days from the date of this letter.

This decision has been made because of your continued refusal to follow the recommended medical treatment plan for [Condition/Reason]. As we have discussed on several occasions, following this treatment is essential for your health and safety. Because we cannot provide the level of care we believe is necessary, we can no longer continue as your healthcare provider.

We will continue to provide you with emergency medical care only until [Date 30 days from now]. This 30-day period is intended to give you ample time to establish care with another physician.

To assist in your transition, we recommend the following resources to find a new provider:

- Your health insurance provider's directory.
- The local medical society.
- [Optional: Name of a specific referral service].

We are happy to transfer a copy of your medical records to your new physician once we receive a signed authorization form from you. You may contact our office at [Phone Number] to request this form or to ask any questions regarding the transfer of your records.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Doctor Name/Clinic Administrator Name]

[Clinic Name]