

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

[Date]

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

Dear [Patient Name],

Please be advised that [Physician Name or Practice Name] will no longer be able to serve as your attending physician. This decision has been made due to your ongoing non-compliance with the medical treatment plans and recommendations discussed during your visits. As a result, we are unable to provide you with the standard of care necessary to manage your health effectively.

We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days, ending on [Date 30 days from now]. This grace period is intended to give you sufficient time to locate a new healthcare provider.

To assist in your transition, we recommend contacting your insurance provider for a list of physicians in your network or contacting the local medical society. Once you have selected a new physician, please sign the enclosed authorization form to have your medical records transferred to their office.

Your health is important, and we strongly encourage you to seek a new physician immediately to ensure your medical needs are met without interruption.

Sincerely,

[Physician Signature]  
[Physician Printed Name]  
[Practice Name]