[Date]

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

Re: Termination of Provider-Patient Relationship

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide medical care to you effective [Date - typically 30 days from letter date].

This decision has been made due to continued non-compliance with the established treatment protocols and practice policies. Specifically, [Optional: Insert brief mention of missed appointments, failure to follow medication plans, or behavior]. This non-compliance makes it impossible to provide you with the standard of care required for your health and safety.

Until the date mentioned above, we will be available to provide you with emergency medical care and necessary prescriptions only. This 30-day period is intended to give you sufficient time to locate a new healthcare provider.

We recommend that you contact your insurance provider or local medical society to assist you in finding a new physician. Once you have selected a new provider, please sign the enclosed medical record release form and return it to our office so that we may transfer your records promptly.

Sincerely,

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

Enclosure: Medical Record Release Form