[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] will no longer be able to provide you with medical services, effective [Date, typically 30 days from letter date].

This decision has been made due to your continued refusal to complete the medical testing recommended on [Date(s)]. These tests are essential for us to accurately diagnose your condition and provide safe, effective treatment. Without these results, we cannot meet the standard of care required to manage your health properly.

Until [Date], we will be available to provide emergency care and necessary prescriptions only. After this date, our physician-patient relationship will be officially terminated.

We strongly advise you to seek a new healthcare provider immediately to ensure your medical needs are met. You may contact your insurance provider or the local medical society for a list of physicians in your area. Upon your written authorization, we will transfer your medical records to your new provider.

Thank you for your cooperation in this transition.

Sincerely,

[Physician Name/Clinic Administrator]
[Clinic Name]
[Phone Number]