

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

RE: Notice of Termination of Medical Care

Dear [Patient Name],

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

This decision has been made because of your continued failure to follow the agreed-upon medical treatment plan and regimen. Consistent adherence to medical advice and prescribed therapies is essential for us to provide you with safe and effective care. Unfortunately, your non-compliance has created a situation where we can no longer effectively manage your health needs.

We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days, until [Date]. This period is intended to give you ample time to establish a relationship with a new healthcare provider.

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

- Your health insurance provider's directory.
- The local medical society.
- [Optional: Hospital Physician Referral Service Name].

We are happy to transfer a copy of your medical records to your new provider. Please sign the enclosed authorization form and return it to our office so we may process the request promptly.

Sincerely,

[Physician Name/Signature]

[Practice Name]

Enclosure: Medical Records Release Authorization Form