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

[Date]

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

RE: Notice of Termination of Medical Care

Dear [Patient Name],

Please be advised that [Clinic Name] is terminating the physician-patient relationship with you effective [Date - 30 days from letter date].

This decision has been made due to your repeated non-attendance of scheduled appointments. Our records indicate that you have missed appointments on the following dates: [List Dates]. As a specialist clinic, consistent attendance is vital for the effective management of your health and the availability of care for all our patients.

We will continue to provide emergency medical care and necessary prescriptions for you until [Date - 30 days from letter date]. This 30-day period is intended to allow you sufficient time to establish care with another specialist.

We recommend that you contact your primary care physician or your insurance provider to obtain a referral to a new [Specialty Type] specialist. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider to ensure continuity of care.

Thank you for your understanding.

Sincerely,

[Physician Name/Clinic Administrator]
[Clinic Name]