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

[Date]

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

RE: Notice of Termination of Orthopedic Care

Dear [Patient Name],

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

This decision has been made due to your continuous missed appointments (no-shows) on the following dates: [List Dates]. Consistent attendance is vital for the successful management of your orthopedic health and the recovery process. Our policy requires reliable attendance to ensure we can provide the highest standard of care to all our patients.

We will continue to provide you with emergency orthopedic care only until [Date]. This 30-day period is intended to allow you sufficient time to locate a new orthopedic provider. We recommend contacting your insurance carrier or your primary care physician for a referral to a new specialist.

Upon your written authorization, we will transfer a copy of your medical records to your new physician. A medical records release form is enclosed for your convenience.

We wish you the best in your future medical care.

Sincerely,

[Physician Name/Clinic Administrator]
[Clinic Name]

Enclosure: Medical Records Release Form