

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

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

This decision has been made due to your history of excessive late cancellations and missed appointments. Our policy requires a minimum of [Number] hours' notice for cancellations to ensure that we can provide care to all patients in need of medical attention. Despite previous notifications regarding this policy, the frequency of your late cancellations has made it difficult to maintain an effective treatment schedule.

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

We recommend that you contact your health insurance provider or visit [State/Local Medical Society Website] to find a new physician. Once you have selected a new provider, please sign the enclosed "Authorization to Release Medical Records" form and return it to our office so that we may transfer your files.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Provider Name/Signature]

[Clinic Name]