Date: [Insert Date]

Patient Name: [Insert Patient Name]
Address: [Insert Patient Address]

Dear [Insert Patient Name],

This letter is to formally notify you that [Insert Practice/Provider Name] will no longer be able to provide you with healthcare services, effective [Insert Date, typically 30 days from letter date].

This decision has been made due to repeated late cancellations of your scheduled appointments. Our policy requires a minimum of [Insert Number] hours' notice for cancellations to ensure we can provide care to all patients in a timely manner. Unfortunately, despite previous discussions, the frequency of late cancellations has made it difficult to maintain an effective treatment schedule.

Until the effective date of [Insert Date], we will remain available to provide emergency care and necessary refills for your current medications. This notice period is intended to give you sufficient time to establish care with a new provider.

We recommend that you contact your insurance provider or use online medical directories to locate a new healthcare provider. Upon receiving a signed authorization form from you, we will transfer your medical records to your new provider to ensure continuity of care.

Thank you for your understanding.

Sincerely,

[Your Name/Signature]
[Your Title]
[Practice Name]