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

[Date]

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

RE: Notice of Dismissal from Medical Care

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you effective [30 Days from Date of Letter]. This decision has been made due to your history of frequent appointment cancellations and missed visits without sufficient notice.

Consistency in scheduling is vital for providing quality healthcare. Your repeated absences have hindered our ability to provide you with proper medical oversight and have impacted our ability to serve other patients.

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

To assist in this transition, we suggest contacting your insurance provider for a list of participating physicians in your area. Upon receiving your written authorization, we will provide a copy of your medical records to your new physician. A records release form is enclosed for your convenience.

We wish you the best in your future health endeavors.

Sincerely,

[Physician Name/Practice Manager]
[Practice Name]

Enclosure: Medical Records Release Form