

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you, effective [Number, typically 30] days from the date of this letter. This decision has been made due to your history of frequent late cancellations and missed appointments, which prevents us from providing consistent care and impacts our ability to serve other patients.

We will continue to provide you with emergency medical care and necessary prescriptions until [Termination Date]. This period is intended to give you sufficient time to locate a new healthcare provider. We recommend that you contact your insurance company or visit local physician directories to find a new provider as soon as possible.

Upon receiving a signed authorization form from you, we will transfer a copy of your medical records to your new physician to ensure a smooth transition of your care.

Thank you for your understanding.

Sincerely,

[Physician/Provider Name]

[Practice Name]

[Phone Number]