[Date]

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

Dear [Patient Name],

Please be advised that you are being formally discharged as a patient from [Practice/Clinic Name], effective immediately. This decision is final and follows the incident on [Date of Incident] involving physical threats made against our medical personnel.

Our practice maintains a zero-tolerance policy regarding violence or threats of violence toward our staff. Such behavior has resulted in a permanent breakdown of the physician-patient relationship, making it impossible to continue your care.

We will provide you with emergency medical treatment for the next 30 days, ending on [Date 30 days from now]. This window is intended to allow you sufficient time to establish care with a new provider. After this date, we will no longer provide any medical services, consultations, or prescription refills.

We recommend you contact your insurance provider or local medical society to locate a new physician as soon as possible. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider.

Sincerely,

[Physician Name/Administrator Name]
[Practice Name]