[Date]

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

Subject: Notice of Discharge from Medical Care

Dear [Patient Name],

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

This decision has been made due to your unresolved financial account balance. We have attempted to work with you by offering [mention previous efforts, e.g., payment plans/financial counseling], but unfortunately, the matter remains unresolved. As a result, we can no longer maintain our physician-patient relationship.

During the next 30 days, we will be available to treat you for emergency situations only. This period is intended to give you sufficient time to locate a new healthcare provider. We recommend contacting your insurance carrier or local medical society to find a new physician.

Upon receiving a signed authorization form from your new provider, we will transfer a copy of your medical records to them to ensure continuity of care.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Doctor Name/Practice Manager]
[Practice Name]