[Date]

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

RE: FINAL NOTICE OF TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

This letter serves as formal and final notification that [Name of Practice/Physician] will no longer be able to provide medical care to you effective [Date - minimum 30 days from date of letter].

The decision to terminate this relationship has been made due to [Reason: e.g., repeated non-compliance with treatment, missed appointments, or failure to maintain a therapeutic relationship].

During the next [Number] days, we will be available to provide care for emergency situations only. This transition period is intended to give you sufficient time to locate a new healthcare provider. We recommend contacting your insurance carrier or the local medical society for assistance in finding a new physician.

We will provide you with a copy of your medical records or transfer them to your new physician upon receipt of a signed authorization form. An authorization form is enclosed for your convenience.

Please ensure you seek continued medical care for any ongoing health conditions. We wish you the best in your future healthcare endeavors.

Sincerely,

[Physician Signature]
[Physician Name]
[Practice Name]

Enclosure: Medical Record Release Authorization Form