

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide you with medical care. This decision has been made due to an irreparable breakdown in the therapeutic relationship and the trust necessary for effective treatment.

Your discharge from this practice will be effective 30 days from the date of this letter, on [Date]. During this 30-day period, we will only be available to provide care for emergency situations or to facilitate the transfer of your care to a new provider.

We recommend that you secure a new physician as soon as possible. You may contact your insurance provider or the local medical society for a list of available practitioners in your area.

Upon receipt of a signed authorization form, we will forward a copy of your medical records to your new physician to ensure continuity of care. A release form is enclosed for your convenience.

Thank you for your cooperation in this transition.

Sincerely,

[Physician Name/Administrator Name]

[Practice Name]

Enclosure: Medical Records Release Form