

[Practice Name]  
[Practice Address]  
[City, State, Zip Code]  
[Phone Number]

[Date]

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

RE: Notice of Termination of the Physician-Patient Relationship

Dear [Patient Name],

Please be advised that [Physician Name/Practice Name] will no longer be able to serve as your medical provider effective [Number, typically 30] days from the date of this letter. This decision has been made due to an irreparable breakdown in the therapeutic relationship, which prevents us from providing you with the optimum standard of care.

Your official discharge date from this practice will be [Date]. Until that time, we will be available to provide care for emergency medical conditions only. This notice period is intended to allow you ample time to establish a relationship with a new healthcare provider.

To assist in your transition, we suggest contacting your insurance provider or the local medical society for a list of physicians currently accepting new patients. In the event of a life-threatening emergency, please call 911 or proceed to the nearest emergency room.

We are happy to transfer a copy of your medical records to your new physician. Please find enclosed a medical record release authorization form. Once signed and returned to our office, we will forward your records promptly.

Sincerely,

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