

[Current Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you effective [Date 30 days from now].

This decision has been made due to your repeated missed appointments on the following dates: [List Dates of No-Shows]. Consistent attendance is necessary for us to provide you with safe and effective medical care. Our policy requires notice for cancellations, and multiple missed visits disrupt the care of other patients.

We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days, until [Date 30 days from now]. This window is intended to give you sufficient time to locate a new healthcare provider.

To assist with your transition, we recommend contacting your insurance provider or the local medical society for a list of available physicians in your area. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider.

Thank you for your cooperation in this matter.

Sincerely,

[Doctor Name/Practice Manager Name]

[Practice Name]

[Phone Number]