

[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 - typically 30 days from date of letter].

This decision has been made because of your continued non-compliance with the treatment plans and medical advice discussed during our appointments. Effective medical care requires a collaborative relationship and adherence to agreed-upon clinical recommendations. Your failure to follow these plans makes it impossible to provide you with the standard of care required.

Until [Date], we will be available to provide you with emergency medical care and necessary prescriptions only. This transition period is intended to give you sufficient time to locate a new healthcare provider.

We recommend that you contact your medical insurance carrier or a local physician referral service to find a new physician. Once you have selected a new provider, please sign the enclosed authorization form so that we may forward a copy of your medical records to their office.

Thank you for your immediate attention to this matter.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Practice Name]