

Date: [Current Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

This letter is to formally notify you that [Provider Name/Practice Name] is terminating the physician-patient relationship. Your discharge from our care will be effective 30 days from the date of this letter, on [Effective Date].

This decision has been made because of your continued refusal to undergo the diagnostic testing recommended on [Date(s) of Recommendation]. These tests, specifically [List Tests, e.g., Blood Work, MRI, etc.], are essential for us to accurately diagnose your condition and provide safe, effective medical treatment. Without these results, we cannot fulfill our professional obligation to provide you with the necessary standard of care.

During the next 30 days, we will be available to treat you for emergency situations only and to assist you in transferring your care to a new provider. We recommend that you find a new physician as soon as possible to ensure your health needs are met. You may contact your insurance provider or the local medical society for a list of available doctors in your area.

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

We wish you the best in your future health care.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Practice Name]