

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

[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 medical care to you as of [Date - Minimum 30 days notice]. This decision is final and follows a formal review of your account/history.

We will continue to provide emergency medical care and necessary prescriptions for you on an interim basis until [Date]. This 30-day period should provide you with sufficient time to establish a relationship with a new healthcare provider.

We recommend that you contact your health insurance provider or the local medical society to locate a new physician who is accepting new patients. It is important for your health that you continue with regular medical follow-ups.

Regarding your medical records, we have enclosed a "Medical Records Release Authorization" form with this letter. Upon receipt of your signed authorization, we will transfer a copy of your medical records to your new physician. Alternatively, we can provide you with a printed or electronic copy for your own files. Please note that [mention any applicable fees or state "there is no charge"] for this transfer.

Thank you for your cooperation in this transition.

Sincerely,

[Doctor Signature]
[Doctor Name]
[Practice Name]

Enclosure: Medical Records Release Authorization Form