

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

[Date]

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

Dear [Patient Name],

We are writing to formally notify you that [Physician Name] will be retiring from medical practice effective [Retirement Date]. As a result, your patient account with this office will be closed on that date.

It has been a privilege to provide for your healthcare needs over the years. To ensure your continued care, we recommend that you begin the process of selecting a new physician as soon as possible. You may contact your insurance provider or the local medical society for a list of available practitioners in your area.

Your medical records remain confidential. We will maintain them in accordance with state and federal laws. If you wish to have your records transferred to a new provider, please complete and return the enclosed "Authorization for Release of Medical Records" form. Please note that there may be a nominal fee for processing and mailing these records.

After [Retirement Date], inquiries regarding records or billing should be directed to [Contact Person/Department] at [Phone Number] or [Email Address].

We wish you the very best in health and wellness.

Sincerely,

[Physician Signature]  
[Physician Name, Title]  
[Practice Name]

Enclosure: Authorization for Release of Medical Records Form