

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Notice of Retirement and Clinic Closure

Dear [Patient Name],

I am writing to formally announce my retirement from medical practice, effective [Last Date of Practice]. Consequently, [Clinic Name] will be permanently closing its doors on that date.

It has been a great privilege to serve as your physician over the years. I am truly grateful for the trust you have placed in me regarding your healthcare needs.

To ensure your continued care, I recommend that you begin looking for a new healthcare provider as soon as possible. You may contact your insurance provider or the local medical society for a list of physicians currently accepting new patients.

Your medical records are confidential and protected by law. To facilitate the transition, you may choose one of the following options:

- Request a copy of your records for yourself.
- Authorize the transfer of your records to a new physician.
- [Optional: Mention name of storage facility or partner clinic] will be the custodian of records after the closure.

Please complete and return the enclosed authorization form by [Deadline Date] to ensure your records are transferred promptly. After [Closure Date], you can reach us at [Phone Number/Email] regarding record requests.

Thank you again for the opportunity to be your doctor. I wish you the very best in health and happiness.

Sincerely,

[Doctor's Signature]

[Doctor's Name]

[Clinic Name]