

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Notice of Clinic Closure and Patient Dismissal

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] will be permanently closing its practice effective [Last Day of Operation]. As a result of this closure, we will no longer be able to provide you with medical care after this date.

Your health and well-being remain our priority. We recommend that you secure a new healthcare provider as soon as possible to ensure there is no interruption in your care. You may contact your insurance provider or the local medical society for a list of available physicians in your area.

Your medical records are confidential. To have your records transferred to a new provider, please complete the enclosed authorization form and return it to us by [Deadline Date]. After the clinic closes, your records will be stored securely at [Location/Storage Facility Name] and can be requested by contacting [Phone Number/Email].

If you have an appointment scheduled after [Last Day of Operation], our office will contact you shortly to cancel or reschedule it before our closing date.

It has been a privilege to serve as your healthcare provider. We wish you the very best in your future health endeavors.

Sincerely,

[Doctor/Administrator Name]

[Clinic Name]

[Clinic Phone Number]