

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

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

It has been a great privilege to serve as your physician. I have truly valued our relationship and the trust you placed in me for your healthcare needs.

To ensure your continued care, I recommend that you begin looking for a new physician as soon as possible. You may contact your insurance provider for a list of in-network doctors or contact the local medical society for a referral.

Your medical records are confidential and protected by law. To transfer your records to a new provider, please complete the enclosed authorization form and return it to our office by [Deadline Date]. After [Clinic Closure Date], your records will be stored at [Storage Facility Name/Location] and can be requested by calling [Phone Number].

If you have an appointment scheduled after [Last Date of Practice], our office will contact you shortly to reschedule or provide assistance with the transition.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic Name]