

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

[Date]

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

Re: Notice of Clinic Closure and Transfer of Care

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] will be permanently closing on [Final Date of Operation]. As of this date, [Doctor/Provider Name] will no longer be able to provide you with medical services.

Your health and continuity of care are our primary concerns. We recommend that you establish care with a new provider as soon as possible to ensure your medical needs are met without interruption. Below are options for your transfer of care:

- [Option 1: Name and contact info of a specific practice taking over the patient list]
- [Option 2: Contact information for your health insurance provider's directory]
- [Option 3: Local physician referral service or Medical Society phone number]

Your medical records are confidential. To have your records transferred to a new provider, please complete the enclosed "Authorization to Release Medical Records" 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 calling [Phone Number].

If you have any current prescriptions that require refills before our closing date, please contact our office no later than [Date] so we can assist you.

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

Sincerely,

[Doctor/Provider Name]  
[Clinic Name]

Enclosure: Medical Record Release Form