

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: 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 Date of Operation]. As a result of this closure, I will no longer be able to serve as your attending physician after this date.

Your health and continued care are our top priorities. We recommend that you establish care with a new physician as soon as possible. If you need assistance finding a new provider, you may contact your insurance company or the local medical society.

To ensure a smooth transition, your medical records must be transferred to your new provider. To facilitate this, please complete the enclosed "Authorization for Release of Medical Records" form and return it to our office by [Deadline Date].

After [Last Date of Operation], your medical records will be stored securely at [Location/Storage Facility Name] for the period required by law. You may request copies or transfers after the closure by contacting [Contact Name/Organization] at [Phone Number/Email].

It has been a privilege to provide for your healthcare needs. We wish you the very best in your future health and wellness.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic Name]