

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Notice of Practice Closure

Dear [Patient Name],

I am writing to formally inform you that I will be closing my medical practice, [Practice Name], effective [Last Date of Operation]. After this date, I will no longer be able to provide you with medical care.

Your health is very important to me, and I want to ensure you have a smooth transition to a new provider. I recommend that you begin looking for a new physician as soon as possible to avoid any gaps in your care. You may contact your insurance provider or the local medical society for a list of available practitioners in your area.

Your medical records are confidential and will be handled in accordance with state and federal laws. To have your records transferred to a new physician or to obtain a copy for yourself, please complete the enclosed authorization form and return it to our office by [Deadline Date]. After [Date], your records will be stored at [Location/Storage Facility Name] and can be requested by calling [Phone Number].

If you have an immediate medical emergency, please call 911 or go to the nearest emergency room. For prescription refills, please contact my office before [Final Date for Refills] to ensure you have an adequate supply during your transition.

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

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[Practice Name]