

[Physician Name]
[Current Practice Name]
[Practice Address]
[City, State, Zip Code]
[Date]

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

RE: Notice of Physician Relocation and Termination of Patient-Physician Relationship

Dear [Patient Name],

I am writing to formally notify you that I will be relocating my medical practice to a new location in [New City/State] and will no longer be practicing at [Current Practice Name] effective [Date of Last Day]. As a result, I will be unable to continue as your physician.

Please be advised that our professional relationship will officially terminate thirty (30) days from the date of this letter, on [Date]. During this 30-day period, I will remain available to you for any emergency medical needs or to provide necessary prescriptions while you transition your care to a new provider.

It is important that you continue with your medical care. You may choose a new physician by contacting your insurance provider for a list of in-network doctors, contacting the local medical society, or by visiting [Website/Resource].

Your medical records are confidential and a copy can be transferred to your new physician or released to you. To facilitate this, please sign the enclosed "Authorization to Release Medical Records" form and return it to our office. We will ensure your records are transferred promptly to ensure continuity of your care.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]