[Doctor Name/Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

Dear [Patient Name],

Please be advised that [Doctor Name/Practice Name] will no longer be able to provide medical care to you as of [Date - typically 30 days from date of letter].

This decision has been made because of your continued refusal to consult with the recommended surgical specialist regarding [Specific Medical Condition]. As previously discussed, this consultation is a critical component of your treatment plan. Without this specialist evaluation, we are unable to provide care that meets the necessary medical standards for your safety and well-being.

Until [Date], we will be available to treat you for any emergency needs or to provide refills for essential medications. This 30-day period is intended to give you sufficient time to locate a new healthcare provider.

We recommend that you contact your health insurance provider or the local medical society to find a new physician. Once you have selected a new provider, please sign the enclosed medical records release form and return it to our office. We will promptly forward a copy of your medical records to your new physician to ensure a smooth transition of care.

Please understand that your medical condition requires ongoing professional attention, and we strongly urge you to seek a new provider and the recommended surgical consultation immediately.

Sincerely,

[Physician Signature]
[Physician Printed Name]