

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

[Date]

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

RE: Notice of Termination of Medical Care

Dear [Patient Name],

This letter is to formally notify you that [Physician Name or Practice Name] will no longer be able to provide medical services to you, effective 30 days from the date of this letter. Your final date as a patient with this practice will be [Date].

This decision has been made because you have repeatedly declined necessary referrals to an Endocrinology specialist. Proper management of your current medical condition requires specialized care that falls outside the scope of this primary care practice. Because you have opted not to follow these essential clinical recommendations, we can no longer safely or effectively manage your health according to the standard of care.

During this 30-day transition period, we will be available only for emergency care or to provide refills for essential maintenance medications. You will need to find a new physician as soon as possible to ensure your medical needs are met.

We recommend contacting your insurance provider for a list of participating physicians in your area, or contacting the local medical society.

Upon receipt of your written authorization, we will transfer a copy of your medical records to your new physician to ensure continuity of care. A medical record release form is enclosed for your convenience.

Sincerely,

[Physician Signature]  
[Physician Name]  
[Practice Name]