

[Date]

[Parent/Guardian Name]

[Address]

[City, State, Zip Code]

RE: [Patient Name] (DOB: [Patient Date of Birth])

Dear [Parent/Guardian Name],

This letter is to formally notify you that [Practice Name] will no longer be able to provide medical care for your child, [Patient Name], effective [Number, e.g., 30] days from the date of this letter. This decision is due to your refusal to follow our clinical recommendation for a specialist referral to [Specialty Name].

As your pediatric providers, we believe this specialist evaluation is essential for the safety and long-term health of your child. Because we cannot provide the standard of care we feel is necessary without this consultation, the physician-patient relationship must be terminated.

We will continue to provide emergency care and necessary prescriptions for your child until [Date 30 days from now]. This window is intended to give you time to select a new pediatrician. We recommend contacting your insurance provider or the local medical society to find a new physician.

Upon your written authorization, we will transfer a copy of [Patient Name]'s medical records to your new provider. We have enclosed a medical record release form for your convenience.

We wish [Patient Name] the best in their future health care.

Sincerely,

[Doctor Name]

[Practice Name]

[Phone Number]