

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you, effective 30 days from the date of this letter. This decision follows your refusal to seek and accept urgent specialist medical care as recommended on [Date] for [Condition/Reason].

Medical standards require that we provide care only when we can ensure your safety. Your refusal to follow urgent specialist recommendations creates a significant risk to your health and prevents us from providing a safe and effective standard of care. Consequently, we can no longer continue as your medical providers.

We will remain available to provide care for emergency situations only until [Date 30 days from now]. This 30-day period is intended to allow you sufficient time to locate a new physician. We recommend you contact your insurance provider or the local medical society to find a new primary care or specialist provider immediately.

Upon receiving 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 Name/Signature]

[Practice Name]

Enclosure: Medical Record Release Form