

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide you with medical care. This decision is effective thirty (30) days from the date of this letter.

This action is being taken due to your continued refusal to follow medical recommendations regarding a necessary specialist referral for [State Condition/Medical Issue]. As previously discussed, our inability to ensure you receive the specialized care required for this condition prevents us from maintaining a safe and effective physician-patient relationship.

During the next 30 days, we will be available to provide you with emergency care and necessary prescriptions only. This period is intended to allow you sufficient time to locate a new healthcare provider. You may contact your insurance carrier or the local medical society for assistance in finding a new physician.

Upon your written authorization, we will transfer a copy of your medical records to your new provider to ensure continuity of care. Please find the enclosed authorization form for this purpose.

We wish you the best in your future health endeavors.

Sincerely,

[Physician Name]

[Practice Name]

Enclosure: Medical Records Release Form