[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 repeated refusal to follow recommended medical treatment plans and diagnostic testing, which we believe are essential for providing you with safe and effective care.

Because we are unable to provide care that meets our clinical standards without your cooperation, we can no longer serve as your medical provider. We will continue to provide you with emergency medical care only until [Date 30 days from now]. After this date, you will need to have established care with another physician.

We recommend that you secure a new physician as soon as possible. You may find a new provider by contacting your insurance company or through your local medical society.

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

Sincerely,

[Doctor Name/Signature]
[Practice Name]

Enclosure: Medical Records Release Form