[Date]

[Parent/Guardian Name]
[Patient Address]
[City, State, Zip Code]

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

Dear [Parent/Guardian Name],

The purpose of this letter is to formally notify you that [Clinic Name] will no longer be able to provide medical care for your child, [Patient Name], effective 30 days from the date of this letter. This decision is based on your refusal to consent to the childhood immunizations recommended by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

At [Clinic Name], we believe that vaccines are essential to the safety of our patients and the community. Because we cannot reach an agreement regarding this fundamental aspect of preventative healthcare, the physician-patient relationship must be terminated.

We will continue to provide emergency care for your child for the next 30 days, until [Insert Date]. This period is intended to give you time to locate a new pediatrician. After this date, we will no longer provide any medical services, including prescription refills or office visits.

We recommend that you contact your health insurance provider or the local medical society to find a new healthcare provider as soon as possible. Once you have selected a new physician, please sign the enclosed medical record release form and return it to our office so that we may transfer your child's medical records.

Sincerely,

[Physician Name]
[Clinic Name]
[Phone Number]