[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: NOTICE OF TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

Please be advised that [Surgeon Name/Practice Name] is terminating the physician-patient relationship with you, effective thirty (30) days from the date of this letter.

This decision has been made because you have declined to consent to the surgical procedure(s) or clinical protocols deemed medically necessary for your safe treatment and recovery. As we are unable to reach an agreement on the required plan of care, we can no longer provide you with effective medical services.

Until [Date 30 days from letter], we will remain available to provide emergency care and necessary prescriptions related to your current condition. This period is intended to allow you sufficient time to establish care with another surgical provider.

We recommend that you contact your insurance provider or the local medical society to locate a new surgeon as soon as possible. Your medical records are confidential. We will transfer a copy of your records to your new physician upon receipt of a signed authorization form, which is enclosed with this letter.

Sincerely,

[Physician Signature]
[Physician Name]
[Practice Name]

Enclosure: Medical Records Release Authorization Form