

[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 has been made because of your continued refusal to follow recommended medical advice and treatment plans, which has resulted in a breakdown of the physician-patient relationship.

Effective [Date 30 days from now], we will officially terminate our professional relationship. We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days while you locate a new primary care provider.

We recommend that you find a new physician as soon as possible to ensure your health needs are met. You may contact your insurance provider or the local medical society for a list of available doctors in your area.

Upon receiving your written authorization, we will transfer a copy of your medical records to your new provider. We have enclosed a medical record release form for your convenience.

Sincerely,

[Physician Name/Practice Manager Name]

[Practice Name]