[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Notice of Dismissal from Care

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] is terminating the physician-patient relationship with you, effective 30 days from the date of this letter.

This decision has been made because you have declined to provide consent for the treatment plan deemed medically necessary for your condition. As a specialty clinic, we require adherence to established safety protocols and clinical interventions to provide effective care. Without your consent to proceed with these necessary treatments, we can no longer fulfill our professional obligations to you as your healthcare provider.

During the next 30 days, we will provide care for emergency situations only. This period is intended to give you sufficient time to locate a new specialist. We recommend contacting your primary care physician or your insurance provider for a referral to a new clinic.

Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider to ensure a smooth transition of care.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Physician Name or Clinic Administrator]
[Clinic Name]