[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. Your final date of care with this practice will be [Date].

This decision has been made because we have reached an impasse regarding your treatment plan. Specifically, your non-consent to the clinically recommended treatment protocols makes it impossible for us to provide you with the standard of care required for your psychiatric health and safety.

During this 30-day transition period, we will be available only for emergency psychiatric care and to provide you with any necessary refills of current medications. We will not be initiating new treatment plans or changing long-term protocols during this time.

We recommend that you secure a new psychiatric provider as soon as possible to ensure continuity of care. You may find a new provider by:

- Contacting your insurance company for a list of in-network providers.
- Contacting your primary care physician for a referral.
- Using the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator.

Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider. We have enclosed an authorization form for your convenience.

Sincerely,

[Provider Name/Signature]
[Practice Name]