

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

[Date]

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

RE: NOTICE OF TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name/Physician Name] will no longer be able to serve as your cardiology healthcare provider effective [Number, typically 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 of your continued refusal to follow the recommended diagnostic tests and treatment plan for your cardiac condition. As we have discussed, these recommendations are essential for managing your health and preventing serious complications. Because we cannot provide the level of care necessary to ensure your safety and well-being without your cooperation in following these medical guidelines, we can no longer maintain a therapeutic relationship.

During this [30]-day transition period, we will be available to provide emergency care only and to facilitate the transfer of your records. We strongly urge you to find a new cardiologist immediately to ensure there is no interruption in your treatment. You may contact your insurance provider or local medical society for a list of cardiologists in your area.

Upon your written authorization, we will provide a copy of your medical records to your new physician. A medical record release form is enclosed for your convenience.

We wish you the best in your future health endeavors.

Sincerely,

[Physician Signature/Name]
[Clinic Name]

Enclosure: Medical Record Release Form