

[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 [Urgent Care Clinic Name] is terminating the provider-patient relationship effective immediately. This decision has been made because of your refusal to consent to the medical evaluations or treatments deemed necessary by our clinical staff to ensure your safety and provide appropriate care.

Because a mutual agreement on your plan of care cannot be reached, we can no longer accept responsibility for your medical treatment.

Please be advised of the following:

- **Emergency Care:** For the next 30 days, we will only provide treatment for life-threatening emergency medical conditions that may arise, to allow you time to establish care with a new provider.
- **Medical Records:** We will provide a copy of your medical records to you or your new healthcare provider upon receipt of a signed authorization form.
- **Future Care:** You are advised to seek a new healthcare provider as soon as possible. If you are experiencing a medical emergency, please call 911 or go to the nearest hospital emergency room.

Sincerely,

[Provider Name/Administrator Name]

[Clinic Name]

[Phone Number]