[Date]

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

Subject: Notice of Discharge from Medical Care

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] and Dr. [Physician Name] are terminating the physician-patient relationship.

This decision follows your refusal to provide informed consent for the surgical procedure recommended for [Condition/Diagnosis]. As we have discussed, this surgery is essential to your treatment plan. Without your consent to the necessary medical intervention, we are unable to provide the standard of care required to treat your condition safely and effectively.

We will continue to provide emergency orthopedic care for you for the next 30 days, until [Date 30 days from now]. This window is intended to give you sufficient time to locate a new orthopedic specialist.

We recommend that you contact your insurance provider or local medical society to find a new physician. Upon receipt of your written authorization, we will transfer your medical records to your new provider to ensure a smooth transition.

Sincerely,

[Physician Name]
[Clinic Name]