[Date]

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

Dear [Patient Name],

This letter is to formally notify you that [Practice Name] will no longer be able to provide you with dermatological medical care. This decision is the result of your refusal to undergo the medical procedures or treatments deemed necessary by our providers for your safety and clinical outcome.

Because the recommended procedure is essential to managing your condition effectively, the disagreement regarding your plan of care has resulted in a breakdown of the physician-patient relationship. We feel it is in your best interest to seek care from another dermatologist who can meet your needs.

We will continue to provide you with emergency care and necessary prescriptions for the next 30 days, until [Date]. This should provide you with sufficient time to establish care with a new physician. After this date, we will no longer be responsible for your medical management.

You may request a copy of your medical records by signing the enclosed authorization form. Upon receipt, we will forward your records to your new physician to ensure a smooth transition of care.

We wish you the best in your future health care endeavors.

Sincerely,

[Physician Name/Practice Manager Name]
[Practice Name]