[Date]

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

Dear [Patient Name],

This letter serves as formal notification that [Clinic Name] is permanently discharging you from our practice and terminating the physician-patient relationship, effective [Date, typically 30 days from notice].

We will continue to provide care for any emergency needs for the next 30 days to allow you sufficient time to establish care with a new provider. After [Date], we will no longer provide any medical services, including prescription refills.

We recommend that you contact your insurance provider or local medical society to locate a new physician as soon as possible. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new provider.

Sincerely,

[Provider Name/Signature]
[Clinic Name]