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

[Date]

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

Subject: Notification of Account Closure

Dear [Patient Name],

This letter is to formally notify you that your account with [Practice Name] has been closed, effective [Date].

According to our records, this account was closed due to:
[Reason: e.g., Request by patient / Completion of treatment / Non-payment / Inactivity]

Important Information Regarding Your Records:
Your medical records remain confidential and will be maintained in accordance with state and federal retention laws. If you wish to transfer your records to a new healthcare provider, please complete the enclosed "Authorization to Release Medical Records" form and return it to our office.

Outstanding Balance:
[Select one: Our records indicate a remaining balance of $[Amount], which is due by [Date]. / Our records indicate that your account is paid in full.]

If you have any questions regarding this notice or believe this closure is in error, please contact our billing department at [Phone Number] between the hours of [Operating Hours].

Thank you for the opportunity to have served your healthcare needs.

Sincerely,

[Name/Signature]
[Title]
[Practice Name]