

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Subject: Notice of Clinic Closure and Transfer of Care

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] will be permanently closing on [Final Date of Operation]. It has been a privilege to serve as your healthcare provider.

To ensure your continued care, we recommend that you begin the process of selecting a new physician as soon as possible. You may contact your insurance provider or the local medical society for a list of practitioners in your area who are accepting new patients.

Your medical records are confidential and protected by law. To transfer your records to a new provider, please complete the enclosed "Authorization to Release Medical Records" form and return it to us by [Deadline Date]. After [Closing Date], your records will be stored at [Storage Location/Facility Name] and can be requested by calling [Phone Number].

If you have any outstanding appointments scheduled after [Closing Date], our office will contact you to reschedule or provide a referral. If you require urgent refills for chronic medications, please contact us before [Date] so we can provide a final 30-day supply to bridge your care.

Thank you for trusting us with your healthcare needs over the years. We wish you continued health and wellness.

Sincerely,

[Doctor Name/Clinic Administrator]

[Clinic Name]

[Phone Number]