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

[Date]

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

Dear [Patient Name],

Please be advised that [Physician/Practice Name] will no longer be able to serve as your medical provider effective [Date - minimum 30 days from date of letter].

This decision has been made due to your continued noncompliance with the recommended treatment plan and [mention specific reason such as: missed appointments / failure to follow medication protocols / failure to complete necessary diagnostic testing]. Consistent adherence to medical advice is essential for us to provide you with safe and effective care.

Until [Date], we will be available to provide you with emergency medical care and any necessary prescriptions to ensure a safe transition. After that date, our physician-patient relationship will formally terminate.

We recommend that you secure a new physician as soon as possible. You may contact your insurance provider or the local medical society for a referral. Once you have selected a new provider, please sign the enclosed medical record release form and return it to our office. We will promptly forward a copy of your medical records to your new physician.

Thank you for your immediate attention to this matter.

Sincerely,

[Physician Signature]
[Physician Name]
[Practice Name]

Enclosure: Medical Record Release Form