

[Date]

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

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] will be relocating to a new city. Our current location at [Current Address] will close permanently on [Closing Date].

Due to the distance of this relocation, I will no longer be able to provide you with medical care effective [Termination Date]. This letter serves as formal notice of the termination of our physician-patient relationship.

Your health is our priority. We recommend that you establish care with a new provider as soon as possible to ensure continuity of treatment. We suggest the following options for finding a new provider:

- Contact your health insurance provider for a list of in-network physicians.
- Contact the [Local/State] Medical Society.
- [Optional: Insert names of local clinics/providers currently accepting new patients].

We are committed to making this transition smooth. Your medical records are confidential and protected by law. To transfer your records to a new provider, please complete the enclosed authorization form and return it to us by [Deadline Date]. After [Closing Date], your records will be stored at [Location/Storage Facility Name] and can be requested by calling [Phone Number].

We will continue to provide emergency care and prescription refills for the next [30/60/90] days, until [Termination Date], to allow you sufficient time to find a new physician.

It has been a pleasure serving as your healthcare provider. We wish you the very best in your future health and wellness.

Sincerely,

[Physician Signature]  
[Physician Printed Name]  
[Clinic Name]

Enclosure: Medical Record Release Authorization Form