

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Termination of Provider-Patient Relationship

Dear [Patient Name],

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

This decision has been made due to your continued non-compliance with the treatment plan discussed and agreed upon on [Date/Multiple Dates]. Effective medical care requires a collaborative relationship and adherence to prescribed therapies, follow-up appointments, and medical advice. Since these requirements are not being met, we can no longer provide you with the standard of care necessary for your well-being.

Until [Date], we will be available to treat you for any emergency medical needs and to facilitate the transfer of your care. We encourage you to secure a new physician as soon as possible to ensure your health needs are addressed without interruption.

To assist in your transition, you may contact your insurance provider or the local medical society for a list of available practitioners in your area. Upon receipt of a signed authorization form, we will provide a copy of your medical records to your new physician.

Sincerely,

[Physician Name/Signature]

[Practice Name]