

[Doctor's Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Date]

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

Subject: Mutual Agreement to Terminate Physician-Patient Relationship

Dear [Patient Name],

This letter serves to formally confirm our mutual agreement to conclude our professional physician-patient relationship, effective [Date].

As discussed during our recent consultation, both parties agree that it is in your best interest to transition your medical care to another provider. We believe this change will better support your ongoing healthcare needs and goals.

To ensure your continuity of care, I will remain available to provide emergency medical services and necessary prescriptions for a period of [Number, e.g., 30] days from the date of this letter. This should provide sufficient time for you to establish care with a new physician.

Your medical records are confidential. Upon receipt of your written authorization, we will forward a copy of your medical history to your new provider. For your convenience, an authorization form is enclosed with this letter.

We suggest contacting your insurance provider or local medical society if you require assistance in locating a new physician.

We wish you the very best in your future health and wellness.

Sincerely,

[Physician Signature]
[Physician Printed Name]

Acknowledged and Agreed:

[Patient Signature]

[Date]