[Date]

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

Dear [Patient Name],

I am writing to formally notify you that I will be closing my medical practice, [Practice Name], effective [Last Date of Operation]. After this date, I will no longer be able to provide medical services or serve as your physician.

Your health and well-being remain my primary concern. To ensure your continuity of care, I recommend that you begin looking for a new healthcare provider as soon as possible. You may wish to contact your insurance provider for a list of in-network physicians or contact the local medical society for a referral.

Your medical records are confidential and will be handled in accordance with state and federal regulations. You have several options regarding your records:

- **Transfer of Records:** If you wish to have your records transferred to a new physician, please complete and sign the enclosed authorization form and return it to our office by [Deadline Date].
- **Record Storage:** After [Last Date of Operation], your records will be stored securely at [Location/Storage Facility Name] for a period of [Number] years. You may request copies during this time by contacting [Phone Number/Email].

If you have an appointment scheduled after [Last Date of Operation], our office will contact you to reschedule or provide assistance with a referral. If you require any prescription refills, please contact my office before [Refill Deadline Date] so we may provide a final 30-day supply to cover your transition period.

It has been a privilege to serve as your physician, and I thank you for the trust you have placed in me over the years. I wish you the very best in your future health.

Sincerely,

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