

Notice of Termination of Healthcare Services

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

City, State, Zip: [Insert City, State, Zip]

Dear [Patient's Name],

We regret to inform you that, effective [Insert Termination Date], we will be terminating our healthcare services provided to you. This decision was made due to [briefly state reason, e.g., change in practice, non-compliance, etc.].

We understand that this may come as a surprise, and we want to ensure that you have adequate time to find alternative healthcare providers. We recommend that you seek a new provider as soon as possible to ensure continuity of care.

Please contact our office if you need assistance in transferring your medical records or if you have any questions regarding this notice. We are committed to your health and will do everything possible to facilitate a smooth transition.

Thank you for the opportunity to serve you.

Sincerely,

[Your Name]

[Your Title]

[Healthcare Provider's Name]

[Contact Information]