

Patient Care Termination Acknowledgement

Date: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Dear [Patient's Name],

This letter serves as formal acknowledgment of the termination of your care with [Provider/Practice Name]. As of [Termination Date], we will no longer be able to provide you with medical services.

The decision to terminate our care was based on [brief reason for termination, if appropriate]. We encourage you to seek alternative medical attention to ensure continuity of care.

Please find enclosed a copy of your medical records for your new provider. If you have any questions or need assistance during this transition, do not hesitate to contact us at [Phone Number] or [Email Address].

We wish you the best in your future healthcare endeavors.

Sincerely,

[Your Name]

[Your Title]

[Provider/Practice Name]

[Contact Information]