

Medical Service Termination Notice

Date: [Insert Date]

[Patient's Name]

[Patient's Address]

[City, State, Zip Code]

Dear [Patient's Name],

We are writing to formally inform you that effective [Last Date of Service], our medical practice will no longer be providing you with medical services. This decision is due to [reason for termination, e.g., change of provider, insurance adjustments, etc.].

We understand that continuity of care is important and recommend that you seek a new medical provider. Enclosed is a list of alternative providers in your area that may meet your needs.

If you require any assistance during this transition, please do not hesitate to contact our office at [Office Phone Number] or [Office Email Address].

Thank you for allowing us to be a part of your healthcare journey. We wish you the best in your continued healthcare.

Sincerely,

[Your Name]

[Your Title]

[Practice Name]

[Practice Address]

[City, State, Zip Code]