

Confirmation of Primary Care Physician Continuity

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient's Name]

[Recipient's Title]

[Medical Practice/Clinic Name]

[Practice Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to confirm the continuity of care with my primary care physician, Dr. [Physician's Name], at [Medical Practice/Clinic Name]. I appreciate the reliable and compassionate care provided thus far and wish to continue receiving treatment under Dr. [Physician's Name]'s guidance.

Please let me know if there are any forms or additional information needed to facilitate this continuity of care.

Thank you for your attention to this matter.

Sincerely,

[Your Name]