utmb Health

Working together to work wonders.™

Date

(Patient name)
(Address)
(City, State, Zip Code)

Re: Certified Receipt #

Dear (Name):

This letter is to inform you that I will be discontinuing my professional relationship with you because of (insert reason). For this reason, we will no longer be able to offer you medical care, effective thirty (30) days from receipt of this letter.

For your continuing medical care needs, I advise that you seek medical attention from another physician as soon as possible. The local medical society can provide you a referral to another physician or you may call your managed care customer service representative.

We will provide copies of your medical records to your new physician. Since your medical records are confidential, your written authorization is required to make them available to another physician. A written release form is attached for this purpose. Please complete the form and return it to my office at your earliest convenience.

Best wishes for your future health.

Sincerely,

(Physician name)
(*Insert Title*)
Department of *(insert department name)*
(insert clinic address)
(insert city, state and zip code)
(insert phone number)

Cc: Medical Director
Practice Manager