

This sample letter will assist you in creating a unique letter for your practice. Please note: The letter's content is general and does not reflect variations in state laws. Consult your state law to ensure compliance with any state-specific rules and regulations.

Sample Patient Notification When Closing a Solo Practice

[Date]

Dear Mr./Mrs./Ms. _____,

I am [closing/retiring from] my practice on [insert date]. I recommend that you find a new physician as soon as possible. For names of physicians in your area, you may contact any of these organizations:

- your medical plan/health insurance company
- the local medical society
- a physician referral service at a hospital you prefer.

[Name of records custodian] will serve as custodian of your medical record. To receive a copy of your record—or to transfer your chart to another physician—please contact [name of records custodian] at [address and phone number of records custodian].

If you wish to continue your care elsewhere, your new physician will need your medical record. [Name of records custodian] must receive your written authorization before it can send your chart to your new physician. For your convenience, I have enclosed an authorization form.

If you have questions, please contact _____ in my office at
(###) ###-####.

Sincerely,

[Signature]
[Physician Name]

Enclosure: Patient Authorization to Release Medical Information form

cc: Patient medical record

This sample letter will assist you in creating a unique letter for your practice. Please note: The letter's content is general and does not reflect variations in state laws. Consult your state law to ensure compliance with any state-specific rules and regulations.

Sample Patient Notification When Leaving or Retiring from a Group Practice

[Date]

Dear Mr./Mrs./Ms. _____,

I am [leaving/retiring from] my practice on [insert date]. I recommend that you find a new physician as soon as possible. [My partner(s)/Dr. _____] [remain(s)/are/is] available to assume your care. Please make an appointment to see [your doctor of choice].

If you prefer, you may contact your medical plan/health insurance company for a list of area physicians. You may also contact the local medical society—or the physician referral service at a hospital of your choice—for names of physicians near you.

If you seek care elsewhere, I will forward a copy of your medical records to your new physician after I receive your written authorization on the enclosed form. You also may use the form to request a copy of your records, which I will send to your attention.

After [my retirement/practice closes], you may request a copy of your records by contacting [name of records custodian] at [address and phone number for records custodian] with your written authorization form.

If you have questions, please contact _____
in my office at (###) ###-####.

Sincerely,

[Signature]

[Physician Name]

Enclosure: Patient Authorization to Release Medical Information form

cc: Patient medical record

This sample letter will assist you in creating a unique letter for your practice. Please note: The letter's content is general and does not reflect variations in state laws. Consult your state law to ensure compliance with any state-specific rules and regulations.

Sample Patient Notification When Selling a Solo Practice

[Date]

Dear Mr./Mrs./Ms. _____,

I am [moving/retiring] and selling my practice to [insert name of physician(s)/group] as of [insert date]. [Insert name of physician(s)/group] [are/is] accepting new patients and may be available to assume your care. Please make an appointment to see [your doctor of choice].

If you prefer, you may contact your medical plan/health insurance company for a list of area physicians. You may also contact the local medical society—or the physician referral service at a hospital of your choice—for names of physicians near you.

If you seek care elsewhere, I will forward a copy of your medical records to your new physician after I receive your written authorization on the enclosed form. You can also use the form to request a copy of your records, which I will send to your attention.

After my [retirement/practice closes], you may request a copy of your records by contacting [name of records custodian] at [address and phone number for records custodian] with your written authorization form.

If you have questions, please contact _____
in my office at (###) ###-####.

Sincerely,

[Signature]

[Physician Name]

Enclosure: Patient Authorization to Release Medical Information form

cc: Patient medical record