This sample letter will assist you in creating a unique letter for your practice. This sample letter is in a general format that does not account for varying state laws. Consult your state law to ensure compliance with any state-specific rules and regulations.

Sample Withdrawal from Care or Termination Letter

[Date]

Dear [Patient's name or name of parent or legal guardian for elderly, minor, or incompetent patients]:

[I/we/the practice] will no longer be your treating physician(s) because of [insert your reason for termination or use language similar to one of the following]:

> *your lack of cooperation in your medical treatment and non-compliance with treatment recommendations; or*
>
> *your not coming in for scheduled appointments; or*
>
> *your lack of follow-through with arrangements to make payments on your account; or*
>
> *your/your child's conduct in my/the office; or*
>
> *the breakdown in our physician-patient relationship.*

While [I/we/the practice] will treat [you/him/her] for emergencies only for the next 30 days, no treatment will be rendered by my office thereafter. The final day [I/we] will be available to provide care to you is [insert date]. [I/we/the practice] recommend you find a new treating physician as soon as possible. Names of other physicians are available through the local medical society at [insert phone number], specialty society at [insert phone number], or local hospital physician referral service at [insert phone number]. You can also contact your health insurance company for a list of physicians who are accepting new patients.

[My/our] office will forward a copy of [your/your child's/etc.] medical record to [your/his/her] new physician upon receipt of your written authorization. A form to authorize us to release a copy of [your/your child's/etc.] medical record is enclosed.

Sincerely,

[Signature]
[Physician's Name]

Enclosure

Note: Withdrawal of care letters should be mailed via regular mail and U.S. Post Office Certified Mail, Return Receipt Requested. A copy of the letter should be kept in the patient's medical record along with the Certified Mail information. Please call ProAssurance Risk Management for assistance.

Sample

This is a sample form to assist you in creating a unique form for your practice. Effective forms address the specific circumstances of each practice.

Sample Patient Authorization to Release Medical Information

Patient Name (Print)	SS or Health Record Number	____/____/______ Patient DOB

______ I authorize (practice/physician's name) to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):______________________________
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- ☐ Consultation reports (please supply doctors' names): ______________________________
- ☐ Other (please describe): ______________________________

[NOTE: If this form is to be used in Michigan by a healthcare provider or facility for authorization by a patient or patient's authorized representative, the highlighted question below should be deleted and replaced with the following statement: "The identified information is being disclosed at the request of the patient or the patient's authorized representative."]

The identified information will be used for the following purpose:

☐ My personal records

☐ Sharing with other health care providers as needed

☐ Other (please describe): ______________________________

Please initial each item below to indicate your understanding.

______ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

______ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

______ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: ______________________________ Name: ______________________________

Address: ______________________________ Address: ______________________________

This authorization will expire on (insert date or event): ______________________________

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

______________________________ ____/____/______

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:______________________________

______________________________ ____/____/______

Witness Signature Date

Distribution of copies: original to practice, copy to patient, copy to accompany information released

SAMPLE