

DATE: _____

SENT VIA CERTIFIED MAIL

PATIENT

Dear _____.

Due to _____, I will no longer be able to continue providing your care. Accordingly, it will be necessary for you to transfer your care to another health care provider. I will continue to provide you with any necessary care until [STATE DATE, USUALLY 30 DAYS OUT], which should give you sufficient time to transfer your care; however, after that date, you will need to obtain medical care elsewhere.

Your condition [MAY/DOES] require continued care. I strongly encourage you to immediately take action to transfer your care to an appropriate health care provider. If you need assistance, [IDENTIFY LOCAL PHYSICIAN REFERRAL SERVICE, IF AVAILABLE] may be able to help you find another appropriate provider. Alternatively, your insurance program, local hospitals, or acquaintances may be able to refer you to an appropriate provider.

We will make your medical records available to your new physician upon his or her request. Please have your provider contact our office to make arrangements to transfer the records. Thank you.

Thank you for allowing me to be involved in your care,

Francisca Onunaku, CNP

One Stop Mental Health Clinic, LLC