Attachment 2 – Discharge Letter

Date

Name
Address
Town, State, Zip

Dear (patient name):

We regret to inform you that we will no longer be able to provide dental care to you. As a consequence, you should make arrangements for your dental care with another dental practice.

To facilitate the transfer of your care to another practice, we have enclosed an authorization form that, once signed, will authorize us to transfer your dental records to your new dental practice. Please sign and return the authorization form so that we can provide a copy of your dental records to your new dentist.

We regret any inconvenience this may cause, but we have many patients who need dental care, and we must give priority to those patients who are responsible about showing up for scheduled appointments.

Sincerely,

(name of dental director or practice manager)