# PATIENT DISCHARGE LETTER

(Enter date)

(Enter patient name and address)

Dear (enter patient's name):

As a result of recent circumstances and, specifically, (reason for discharge) we have decided that you will need to seek future medical care elsewhere.

We will be available to meet your health care needs only until (45 days after the date of this letter) Month ##, Year. After this date you need to access care from another provider. (Enter name of local clinic) is a local clinic that also provides medical care.

Be mindful, if you have insurance or are enrolled in other health care coverage programs it is your responsibility to contact the carrier or the program regarding this change in you care provider. If you are a Medicaid Member of Integrated Community Health Partners (ICHP), you may contact Member Services at **855-959-7340 (toll free).**

Upon submitting an appropriate request to our medical records department, we will also be happy to transfer your records to the health care provider you choose.

Sincerely,

*Signature, CEO or COO*
Certificate of Mailing
Mailed on Date

Copies to: Patient Record
ICHP
BHO