MONTH DATE, YEAR

**McLaren Region -**

**Office Name**

STREET ADDRESS, SUITE #

CITY, MI ZIP

tel: (000) 000-0000

fax: (000) 000-0000

mclaren.org/officeURL

Dear Patient:

McLaren Region – Office Name regrets to inform you First Last, Credential, will no longer be a part of McLaren Medical Group, effective Month Date, Year.

If your health insurance requires the designation of a primary care provider, you will need to contact your insurance company to declare your new selection.

Please be assured we are committed to maintaining continuity of care for you and your family. Our highest priority is to ensure your transition to a new provider is seamless. Below is a list of McLaren Medical Group providers who will continue to offer you high-quality, patient-centered care.

|  |  |  |  |
| --- | --- | --- | --- |
| Provider | Specialty | Office | Telephone |
| First Last, Credential | Specialty | **Location Name**  Address | (000) 000-0000 |
| First Last, Credential | Specialty | **Location Name**  Address | (000) 000-0000 |
| First Last, Credential | Specialty | **Location Name**  Address | (000) 000-0000 |

*\*IF YOU WISH TO INCLUDE MORE THAN 3 PROVIDERS, PLEASE INSERT ROWS\**

If you have questions concerning your care or would like to schedule an appointment, please call our office at (000) 000-0000. Your medical records will remain at this office unless otherwise indicated.

It is our hope should you or your family require health care services in the future, we have the opportunity to be of service to you. Thank you for entrusting McLaren with your health care.

Sincerely,

*Upload signature(s) in the Special Notes/Attachments section of Request Form.*

Director’s First Last Name

Region Name

McLaren Medical Group