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:

First Last Name, Credential, and First Last Name, Credential, are pleased to announce the merger of their practices, forming McLaren Region – Office Name. We look forward to providing high-quality, patient-centered care to a wider area beginning Month Date, Year.

**Location Name**

**Street Address, Suite #**

**City, MI Zip**

**tel: (000) 000-0000**

**fax: (000) 000-0000**

**Office hours:**

**Mon-Fri: X a.m.-X p.m.**

**Sat-Sun: X a.m.-X p.m.**

This merger and move will not affect your care and we look forward to seeing you at our new location.

For more information prior to Month Date, Year, please contact your provider’s current office. **After Month Date, Year, please call (000) 000-0000 for questions or to make your appointment.**

Thank you for entrusting McLaren with your health care needs.

Sincerely,

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

First and Last Name, Credential First and Last Name, Credential

Specialty Specialty

McLaren Medical Group McLaren Medical Group