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:

As of Month Date, Year, I/we will be relocating to McLaren Region – Office Name. A short X- minute drive from my/our existing office, I/we will now be providing care at the following location:

**McLaren Region
Office Name**

Street Address, Suite #

City, MI Zip

tel: (000) 000-0000

fax: (000) 000-0000

Though our address will change, our commitment to providing high-quality,
patient-centered care remains our priority. This move will not affect your care and I am/we are excited to share my/our new space with you.

To make an appointment with me/us at my/our new location, please call
(000) 000-0000. For more information about my/our new office,
visit mclaren.org/officeURL.

Thank you for entrusting McLaren with your health care needs. I/We look forward to continuing your care at our new location.

Sincerely,

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

First Last Name, Credential

Specialty

McLaren Medical Group