Texas Medical Board
Mailing Address: PO Box 2029, MC-245, Austin, Texas 78768-2029
Phone: (512) 305-7030

NOTIFICATION OF DEPARTURE/CLOSURE OF PRACTICE

In accordance with Texas Medical Board (TMB) Board Rule 165.5 when a physician retires, terminates employment, or otherwise leaves a medical practice, he or she is responsible for:

(1) ensuring that patients receive reasonable notification and are given the opportunity to obtain copies of their records or arrange for the transfer of their medical records to another physician; and

(2) notifying the board when they are terminating practice, retiring, or relocating, and therefore no longer available to patients, specifying who has custodianship of the records, and how the medical records may be obtained.

Employers of the departing physician as described in §165.1(b)(6) of this chapter are not required to provide notification, however, the departing physician remains responsible, for providing notification consistent with this section.

Please print or type your information:

License information:	Physician name _____ License number	
Name and address of practice you are leaving/closing:		
Type of Practice:	❒ Solo ❒ Partnership/group ❒ Other _____	❒Hospital based ❒Clinic – Hospital affiliated
Reason for transfer of records:	❒ Retiring ❒ Relocating	❒ Practice closing ❒ Other (please provide explanation)
Check the box describing the documents you are providing:	❒ Notice on website or in the newspaper ❒ Written notice in the Physician's office ❒ Letters or emails to patients seen in the last two years	
Physician's email contact information:		
Person and/or entity that will be the custodian of the medical records:		
Contact information for custodian of records:	Mailing address _____ Phone number	

I certify that all statements I have made herein are true to the best of my knowledge.

Date change becomes effective: _____

Signature (Required): _____
Signature **Date**

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NOTIFICATION OF DEPARTURE/CLOSURE OF PRACTICE
ADDRESS UPDATE

Please keep this Board informed of any changes in your addresses. This will ensure receipt of your renewal notices and permits, as well as other Board correspondence.

Please print or type your new information:

Name:_____

License Number:_____

MAILING ADDRESS:	PRACTICE ADDRESS/CONTACT ADDRESS FOR PUBLIC PROFILE:
_____ Street or P O Box	_____ Street
_____ Suite or Room No.	_____ Suite or Room No.
_____ City, State, Zip	_____ City, State, Zip

Date change becomes effective: _____

Signature (Required)**:** _____.
Signature **Date**

Return these completed forms by **mail, email OR fax.** Please do not submit multiple copies. The submission of multiple copies may increase processing time.

Mail to: Texas Medical Board
P.O. Box 2029, MC 245
Austin, Texas 78768-2029

Email to: Registrations@tmb.state.tx.us

Fax to: 888-512-2581