

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

RE: TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

Please be advised that [Practice Name] and its providers will no longer be able to provide medical care to you effective [Date - typically 30 days from letter date]. This decision is final.

This termination is a direct result of the discovery that you provided false or misleading information regarding your medical history, current medications, or personal identity. The physician-patient relationship is built on trust and the exchange of accurate information. Falsification of medical records compromises our ability to provide safe and effective treatment and violates our practice policies.

Until the effective date mentioned above, we will be available to treat you for any emergency needs only. This 30-day period allows you sufficient time to establish care with another healthcare provider. We recommend you contact your insurance carrier or local medical society to locate a new physician.

We are happy to transfer a copy of your medical records to your new provider. Please sign the enclosed "Authorization to Release Medical Records" form and return it to our office so that we may facilitate this transfer promptly.

Sincerely,

[Physician Name/Administrator Name]

[Practice Name]

Enclosure: Medical Record Release Authorization Form