

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Termination of Provider-Patient Relationship

Dear [Patient Name],

Please be advised that [Clinic Name] is formally terminating our provider-patient relationship effective [Number, typically 30] days from the date of this letter. This means that after [Date], no further appointments will be scheduled, and we will no longer provide your medical care.

This decision has been made because of a violation of our clinic policy regarding unauthorized recording. On [Date of incident], it was discovered that you were recording audio or video within the clinic without the consent of the staff or providers. Our policy exists to protect the privacy and confidentiality of all patients and staff members. This breach of policy has resulted in an irreparable breakdown of the trust necessary for a therapeutic relationship.

During the next [Number] days, we will provide care for emergency situations only. This transition period is intended to give you sufficient time to locate a new healthcare provider. We recommend contacting your insurance carrier or local medical society for assistance in finding a new physician.

Upon your written authorization, we will transfer a copy of your medical records to your new provider. A medical record release form is enclosed for your convenience.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Provider Name or Practice Manager Name]

[Clinic Name]

Enclosure: Medical Record Release Form