[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: NOTICE OF TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide medical care to you. This decision is effective as of [Date, typically 30 days from letter date].

This termination is a result of the discovery that information provided in your medical records was falsified. Trust and honesty are essential components of the physician-patient relationship. The provision of inaccurate or misleading information prevents us from providing safe and effective medical treatment.

Until [Date], we will be available to treat you for emergency situations only. This notice period is intended to give you sufficient time to locate a new healthcare provider. We recommend that you contact your insurance company or local medical society to find a new physician as soon as possible.

Upon receipt of your written authorization, we will provide a copy of your medical records to your new physician to ensure continuity of care. A medical record release form is enclosed for your convenience.

Sincerely,

[Physician Name/Administrator Name]
[Practice Name]

Enclosure: Medical Record Release Form