[Date]

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

Re: Notice of Termination of the Provider-Patient Relationship

Dear [Patient Name],

Please be advised that [Clinic Name] and its providers are terminating the provider-patient relationship with you, effective [Date, typically 30 days from letter date].

This decision has been made due to the discovery of falsified information within your patient health records. The integrity of medical records is essential for providing safe and effective care. Providing false information undermines the trust necessary for a therapeutic relationship and poses a significant risk to your clinical safety.

Until the effective date mentioned above, we will remain available to provide emergency care and necessary prescriptions only. This transition period is intended to allow you ample time to secure a new healthcare provider.

We recommend that you contact your health insurance carrier or consult local medical directories to find a new provider as soon as possible. Upon receipt of a signed authorization form, we will transfer a copy of your medical records to your new physician to ensure continuity of care.

Sincerely,

[Authorized Signature]
[Printed Name and Title]
[Clinic Name]