[Doctor/Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[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 [Doctor/Practice Name] will no longer be able to provide medical care to you effective [Number, e.g., 30] days from the date of this letter. Your final date of service with this practice will be [Date].

This decision has been made due to the misrepresentation of your medical history. A complete and accurate medical history is essential for providing safe and effective healthcare. The provision of inaccurate or incomplete information has compromised the physician-patient relationship and our ability to maintain a standard of care.

During this transition period, we will be available to provide care only for acute emergencies or to facilitate the transfer of your records. We recommend that you secure a new healthcare provider as soon as possible to ensure continuity of your medical treatment.

Upon receipt of your written authorization, we will forward a copy of your medical records to your new physician. For your convenience, a records release form is enclosed with this letter.

You may contact your health insurance provider or the local medical society for assistance in locating a new physician.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Practice Name]

Enclosure: Medical Records Release Form