[Date]

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

RE: Notice of Discontinuation of Care

Dear [Patient Name],

Please be advised that [Practice/Physician Name] will no longer be able to provide medical care to you, effective [Number, typically 30] days from the date of this letter. Your final date of service with this practice will be [Final Date].

This decision has been made following a review of your medical record, which indicates that fraudulent medical documentation was provided to this office. The integrity of the physician-patient relationship is based on mutual trust and honesty. The submission of falsified or altered documents makes it impossible to maintain the standard of care required for your treatment.

Until [Final Date], we will be available to provide emergency care only or to assist you in the transition to a new provider. We recommend that you secure a new physician as soon as possible to ensure continuity of your healthcare. You may contact your insurance provider or the local medical society for a list of available physicians in your area.

We will provide a copy of your medical records to your new physician upon receipt of a signed authorization form. You may find this form enclosed or available at our front desk.

Sincerely,

[Physician Signature]
[Physician Name]
[Practice Name]