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

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

RE: TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

Please be advised that [Physician Name/Practice Name] is officially terminating the physician-patient relationship with you, effective [Number, typically 30] days from the date of this letter.

This decision has been made due to the discovery of inconsistencies and deceptive information provided regarding your medical history and records. The provision of accurate medical information is essential for maintaining a safe and effective treatment environment. The loss of trust resulting from this deception has made it impossible to continue providing you with appropriate care.

Until [Effective Date], we will remain available to provide care for emergency situations only. This notice period is intended to allow you sufficient time to establish care with another provider. We recommend that you contact your insurance carrier or local medical society to locate a new physician immediately.

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

Sincerely,

[Signature]

[Printed Name and Title]

Enclosure: Medical Records Release Form