[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 [Practice Name] is terminating its professional relationship with you, effective [Number, typically 30] days from the date of this letter. After this date, you will no longer be seen as a patient at this facility.

This decision has been made due to a violation of our practice policies regarding unauthorized photography and/or recording within the clinic. On [Date of Incident], it was observed that you were [filming/taking photographs] in a manner that violates our patient privacy (HIPAA) protocols and our code of conduct.

Until [Date 30 days from now], we will be available to provide you with emergency medical care only. This notice period is intended to give you sufficient time to locate a new healthcare provider. We recommend contacting your insurance carrier or the local medical society for a list of available physicians in your area.

Upon receipt of your written authorization, we will transfer a copy of your medical records to your new physician to ensure continuity of care. You may find the authorization form attached to this letter or on our website.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Physician Name or Practice Manager]
[Title]
[Practice Name]