[Date]

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

Dear [Patient Name],

Please be advised that [Practice Name] is terminating the physician-patient relationship with you effective [Number, typically 30] days from the date of this letter. After this date, we will no longer be able to provide you with medical care.

This decision has been made due to a violation of our practice's Privacy Policy. Specifically, on [Date of Incident], the following occurred: [Brief description of privacy breach, e.g., unauthorized access to records, recording staff without consent, or sharing confidential practice information]. Such actions constitute a breach of the trust necessary for a professional medical relationship.

During this transition period, we will be available to provide emergency care and necessary prescriptions only. This coverage will end on [Final Date of Coverage].

We recommend that you secure a new physician as soon as possible. You may contact your insurance provider or the local medical society for a list of available practitioners in your area.

Your medical records are confidential. We will transfer a copy of your medical records to your new physician upon receipt of a signed written authorization from you. An authorization form is enclosed for your convenience.

Sincerely,

[Physician Name/Practice Manager]
[Practice Name]

Enclosure: Medical Records Release Authorization Form