[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 [Date, typically 30 days from letter].

This decision has been made due to a violation of our practice policies regarding nonconsensual photography. It has come to our attention that on [Date of Incident], you took photographs or video recordings of [Staff Name/Patients/Clinical Areas] without obtaining prior authorization or consent.

Such actions constitute a breach of privacy and a breakdown of the necessary trust required for a therapeutic relationship. Consequently, we can no longer provide you with medical care.

During the next [Number of Days] days, we will be available to provide care for emergency situations only. This transition period is intended to allow you sufficient time to establish care with another provider. You may contact your insurance company or the local medical society for assistance in finding a new physician.

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

Sincerely,

[Physician Name/Signature]
[Practice Name]