[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] will no longer be able to provide medical care to you effective [30 days from date of letter].

This decision has been made due to the repeated use of unauthorized medical devices or software that have not been prescribed, approved, or monitored by this office. The use of such devices interferes with our ability to provide safe, evidence-based care and poses significant risks to your clinical safety and data integrity.

We will continue to provide emergency care and necessary prescriptions for the next 30 days, until [Date], to allow you sufficient time to find a new healthcare provider. After this date, we will no longer treat you or provide refills.

We recommend that you contact your health insurance provider or a local medical society to assist you in locating a new physician. Once you have selected a new provider, please sign the enclosed medical record release form and return it to our office so that we may transfer your records promptly.

Sincerely,

[Physician Name/Administrator Name]
[Practice Name]

Enclosure: Medical Record Release Form