[Date]

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

Dear [Patient Name],

Please be advised that [Practice Name] will no longer be able to provide medical care to you effective [Number, typically 30] days from the date of this letter. This decision has been made due to a general conflict of interest that prevents the maintenance of an appropriate physician-patient relationship.

Until [Date of Termination], we will remain available to provide care for any emergency needs you may have. This period is intended to give you sufficient time to establish care with a new healthcare provider.

We recommend that you contact your insurance provider or local medical society to locate a new physician. Once you have selected a new provider, please sign the enclosed medical record release form and return it to our office. We will then forward a copy of your medical records to your new physician to ensure continuity of care.

Thank you for your cooperation during this transition.

Sincerely,

[Doctor Name/Signature]
[Practice Name]