[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Notice of Termination of Medical Care

Dear [Patient Name],

This letter is to formally notify you that [Physician/Practice Name] will no longer be able to provide medical services to you, effective 30 days from the date of this letter. This decision is due to a financial conflict of interest that prevents us from maintaining the necessary professional relationship required for your care.

We will continue to provide emergency medical care and necessary prescriptions for you until [Date 30 days from now]. This window of time is intended to allow you to secure a new healthcare provider. After this date, we will no longer be your medical provider.

We recommend that you contact your insurance company or use a physician referral service to find a new provider as soon as possible. Once you have selected a new physician, please sign the enclosed medical records release form and return it to our office. We will forward a copy of your medical records to your new provider to ensure a smooth transition.

Thank you for your understanding regarding this matter.

Sincerely,

[Physician Signature]
[Physician Printed Name]

Enclosure: Medical Records Release Form