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

[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 [Physician Name/Practice Name] will no longer be able to provide medical care to you effective [Date, typically 30 days from letter date].

This decision has been made due to a personal relationship conflict that we believe creates a boundary issue and prevents us from maintaining the necessary professional objectivity required for your medical treatment. To ensure you receive the highest standard of care, it is best that you establish a relationship with a provider where no such conflict exists.

We will continue to provide you with emergency medical care and necessary prescriptions for the next 30 days, until [Date]. This period should allow you ample time to locate a new healthcare provider.

We recommend contacting your insurance carrier or the local medical society to find 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 forward a copy of your medical records to your new physician to ensure a smooth transition of care.

Thank you for your understanding regarding this matter.

Sincerely,

[Physician Signature]
[Physician Name]
[Practice Name]