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

[Date]

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

Dear [Patient Name],

Please be advised that [Practice Name / Physician 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 because the current pending litigation between us has created a conflict of interest that makes it impossible to maintain the necessary physician-patient relationship. Professional standards require a relationship built on mutual trust and cooperation, which we believe can no longer be sustained under these circumstances.

Until the effective date of [Date], we will be available to treat you for any emergency needs or urgent medical issues only. This 30-day period is intended to provide you with ample time to establish care with a new provider.

We recommend that you contact your health 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 promptly forward a copy of your medical records to your new physician to ensure continuity of care.

Sincerely,

[Physician Name/Signature]
[Title]

Enclosure: Medical Record Release Form