[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 you with medical care. This decision has been made due to a conflict of interest that has arisen, which prevents us from maintaining the necessary objective provider-patient relationship required for your treatment.

Your formal dismissal from this practice will be effective 30 days from the date of this letter, on [Final Date of Service]. During this 30-day period, we will be available to provide care for emergency situations only and to facilitate the transfer of your care to a new provider.

To ensure your continued health and safety, we recommend that you secure a new physician as soon as possible. You may find a new provider by:

- Contacting your health insurance provider for a list of in-network clinicians.
- Contacting the local Medical Society at [Phone Number].
- Using the "Find a Doctor" tool on your insurance company's website.

We are happy to transfer a copy of your medical records to your new physician once we receive a signed written authorization form. We have enclosed a medical record release form for your convenience.

We wish you the best in your future healthcare endeavors.

Sincerely,

[Provider Name/Signature]
[Practice Name]

Enclosure: Medical Record Release Form