[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 [Date, typically 30 days from letter date].

This decision has been made due to ongoing conflicts regarding the treatment and management of your immediate family member, [Family Member Name], who is also a patient at this practice. We believe that the current situation has created a breakdown in the therapeutic relationship and a conflict of interest that prevents us from providing the high standard of care you deserve.

We will continue to provide emergency care and necessary prescriptions for the next 30 days while you locate a new healthcare provider. This will allow you ample time to transition your care. We recommend contacting your insurance provider or the local medical society to find a new physician.

Upon receiving a signed authorization form, we will transfer a copy of your medical records to your new provider to ensure continuity of care. You may pick up an authorization form at our front desk or we can mail one to you.

We wish you the best in your future health endeavors.

Sincerely,

[Physician Name/Practice Manager Name]
[Practice Name]