[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 because of a conflict regarding professional boundaries, which has resulted in a breakdown of the essential physician-patient relationship.

Effective [Date, typically 30 days from letter date], our professional relationship will be formally terminated. We will continue to provide care for any emergency needs until that date to allow you sufficient time to secure a new healthcare provider.

We recommend that you contact your insurance provider or the local medical society to find a new physician as soon as possible. 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.

Thank you for your cooperation in this transition.

Sincerely,

[Physician Name]
[Practice Name]

Enclosure: Medical Record Release Form