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

[Date]

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

RE: Notice of Termination of Provider-Patient Relationship

Dear [Patient Name],

Please be advised that [Practice Name / Physician Name] will no longer be able to provide you with medical care. This decision has been made due to a conflict of interest arising from your recent employment or professional affiliation with [Organization/Company Name], which creates a boundary issue that prevents us from maintaining an objective provider-patient relationship.

The termination of this relationship will be effective 30 days from the date of this letter, on [Date]. During this 30-day period, we will be available to provide you with emergency care and necessary prescriptions only.

We recommend that you secure a new healthcare provider as soon as possible. You may contact your insurance provider or the local medical society for a list of available physicians in your area.

Upon receipt of your written authorization, we will provide a copy of your medical records to your new physician to ensure a smooth transition of your care. We have enclosed a medical record release form for your convenience.

Thank you for your understanding regarding this professional necessity.

Sincerely,

[Physician Name/Signature]
[Title]