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

[Date]

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

RE: NOTICE OF TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

Dear [Patient Name],

This letter is to formally notify you that [Physician Name/Practice Name] will no longer be able to provide you with medical care. This decision is effective as of [Final Date, typically 30 days from date of letter].

This termination is a result of a breach of the Pain Management Agreement signed on [Date]. Specifically, the agreement was violated due to [Reason, e.g., unauthorized dose escalation, obtaining prescriptions from multiple providers, or failed toxicology screening]. This breach has caused an irreparable breakdown in the physician-patient relationship, making it impossible to continue providing safe and effective treatment.

During the next 30 days, we will continue to provide care for emergency situations only. This period is intended to allow you sufficient time to locate a new healthcare provider. You may contact your insurance carrier or the local medical society for a list of physicians currently accepting new patients.

Regarding your pain management medications, [choose one: no further refills will be provided / a final limited supply of [Medication] will be provided on [Date] to prevent withdrawal during your transition]. After this date, you must obtain all prescriptions from your new provider.

We will transfer a copy of your medical records to your new physician once we receive a signed Authorization to Release Records form, which is enclosed with this letter.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name]