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May 23, [REDACTED]

By US Mail, Certified & Non-Certified

**RE: Physician / Patient Relationship**  
[REDACTED] Medical Record ID [REDACTED]  
[REDACTED]

This letter will confirm our decision to withdraw from your care effective upon receipt of this letter. It does not appear that we can maintain the quality of physician-patient relationship that is required for your medical care and treatment.

At this time, we encourage you to seek gastroenterology care from another physician outside of Texas Digestive Disease Consultants.

Since your condition may require further medical for the finding of a [REDACTED] on CT scan, I suggest that you select another physician without delay. As our practice manager has explained to you, I will be available to treat you for urgently required services only 30 days following your receipt of this letter.

Your referring physician (Dr. [REDACTED]) and I have spoken about options for you to transfer your care to another healthcare provider.

We want you to understand that your condition may require ongoing specialty care, and it is important that you seek medical attention from another source in the near future per the recommendations of your primary care physician.

Enclosed is an authorization to release a copy of your medical record to the physician or clinic of your choice. Upon receipt of the signed form, my office will prepare a copy and mail it to your selected recipient.

Sincerely

Neville Fernandes, M.D.

Encl

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