SOUTHWEST VIRGINIA
**Nephrology Medicine** PC

Fletcher Matthews, MD
4806 Pleasant Hill Drive | Suite 102
Roanoke, VA 24018-3441
p: 540-904-5366 | f: 540-904-5598
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July 2, 2020

To Our Valued Patients,

I am writing to inform you that I will be closing my practice as of 7/31/20.

I would like to thank you for your trust you have given me over the years as your physician. Taking care of your nephrology needs has been an honor for my staff and me. Your continued wellness and health is a priority. It is important that you continue with the appropriate care and establish with a new Nephrologist as soon as possible.

Enclosed is a medical release form. Your records will be stored at Blue Ridge Nephrology, Dr Paul LaFlam's office. Please send your release to them. They will be glad to send your records to your new physician.

We apologize for the nature of this letter, It has been a difficult decision for all involved.

Below are a few options for continued care:

| | | |
|---|---|---|
| Valley Nephrology Associates | Blue Ridge Nephrology | Lynchburg Nephrology |
| 2602 Franklin Road SW | 2900 Lamb Circle #190 | 2901 Langhorne Road |
| Roanoke, VA 24014 | Christiansburg, VA 24073 | Lynchburg, VA 24501 |
| (540) 344-1400 | (540) 633-5650 | (434) 947-3954 |

Sincerely,

Fletcher G. Matthews, M.D.

# MEDICAL RELEASE FORM

Fletcher Matthews, MD
Southwest Virginia Nephrology Medicine
4806 Pleasant Hill Drive, Suite 102
PH: 540-904-5366 Fax: 540-904-5598

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

**Information To Be Released From (Physician Office Information)**

Name: Fletcher Matthews, MD
Southwest Virginia Nephrology Medicine PC
Address: 4806 Pleasant Hill Drive, Suite 102
City: Roanoke, VA, 24018
Phone: 540-904-5366 Fax: 540-904-5598

**Purpose of Release:** ☒ Continuity of Care ☒ Transfer Care ☐ Other

**This request and authorization applies to:**

☐ All Healthcare Information

☒ Healthcare Information relating to the following treatment, condition, or dates: Nephrology Office Notes, Xrays, Labs

☐ Other (specify): _____

Patient Signature: _____ Date Signed: _____

**Information To Be Released To (Physician Office Information)**

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____