MEDICAL DEBT VALIDATION LETTER

Debt Collector Name: _____

Debt Collector Address: _____

Account Number: _____

Patient Name: _____

I am writing to request validation of the alleged medical debt referenced above. This request is made pursuant to my rights under the Fair Debt Collection Practices Act (FDCPA), 15 U.S.C. § 1692g, and the Health Insurance Portability and Accountability Act (HIPAA), as applicable.

1. Debt Validation

Please provide me with the following information to validate this alleged debt: a) The amount of the debt; b) The name of the creditor to whom the debt is currently owed; c) Detailed itemized statements or billing records from the original healthcare provider(s) showing the services rendered and dates of service; d) Copies of any contracts, agreements, or documents bearing my signature evidencing my responsibility for the debt.

2. Verification of Debt Ownership

Please provide documentation demonstrating your authorization to collect on this debt, including the original creditor's assignment of the debt and your licensing information as a debt collector.

3. Dispute of Debt

I dispute the validity of this alleged debt in full. Until you provide the requested validation information, you are required to cease all collection activities and communications with me, except to provide the validation.

4. Request to Cease Communications

Please consider this letter as a formal written request to cease all further communications with me about this alleged debt, except to notify me of any specific actions you intend to take as permitted by law.

5. HIPAA Compliance

I request that you provide a copy of your HIPAA Notice of Privacy Practices and any authorization forms you possess related to my medical information. I do not authorize any disclosure of my medical information without my explicit written consent.

6. Prohibition of Negative Credit Reporting

Until this debt is fully validated, you must not report this alleged debt or any related information to any credit reporting agencies.

7. Legal Rights and Remedies

Be advised that any failure to comply with the FDCPA, HIPAA, or any other applicable federal or state laws may result in legal action against you. I reserve all rights to seek remedies, including damages and attorney's fees.

8. Contact Information

Please send all correspondence and requested documentation to the address listed below. I will not accept telephone communications regarding this matter.

9. Good Faith Cooperation

I expect your prompt and good faith cooperation in this matter. Failure to respond adequately will be interpreted as a violation of my rights.

10. Signature

Respectfully, _____ Signature Printed Name: Address: Phone: Email:

Sender's Signature **Date**

Signature: _____ Date: _____