[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Debt Collector Name]
[Debt Collector Address]
[Debt Collector City, State, Zip Code]

RE: Account Number [Insert Account Number]

Dear [Debt Collector Name],

I am writing to formally dispute the debt mentioned above and to request validation of this medical debt pursuant to the Fair Debt Collection Practices Act (FDCPA), 15 U.S.C. $ 1692g.

I am requesting that you provide the following information:

- The name and address of the original medical service provider.
- The date(s) of service and a description of the services provided.
- An itemized statement of the total amount owed, including any payments, credits, or insurance adjustments applied to the account.
- Evidence that you are legally authorized to collect this debt.
- Documentation showing that the statute of limitations for collecting this debt has not expired.

Please note that if this debt involves protected health information, you must comply with all HIPAA regulations regarding the disclosure of my medical records.

Be advised that I am also requesting you cease all credit reporting of this account until the debt has been fully validated. If this information has already been reported to credit bureaus, please mark the account as "disputed."

I look forward to receiving the requested documentation within 30 days of your receipt of this notice.

Sincerely,

[Your Signature]
[Your Printed Name]