Consent for Medical Debt Reporting Adjustment

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], born on [Your Date of Birth], residing at [Your Address], hereby give my consent for the adjustment of my medical debt reporting as outlined below.

Account Number: [Insert Account Number]

Service Provider: [Insert Service Provider Name]

Original Amount: [Insert Original Amount]

Adjusted Amount: [Insert Adjusted Amount]

Reason for Adjustment: [Briefly Describe Reason]

I understand that this consent allows [Service Provider or Agency Name] to make necessary modifications to my medical debt reporting to reflect the agreed-upon adjustments.

I affirm that I have provided accurate information and understand that this consent is voluntary.

Signature: _____

Name: [Your Printed Name]

Date: [Insert Date]

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Contact Information]