

MID VALLEY DERMATOLOGY

Allan S. Wirtzer, M.D., Medical Director

ADULT & PEDIATRIC DERMATOLOGY • DERMATOLOGIC SURGERY • LASER SURGERY • COSMETIC DERMATOLOGIC SURGERY

I authorize Mid Valley Dermatology to release "Billing Information" to:

Name _____
 Address _____
 Phone# _____
 Contact Person _____

I understand that "Billing Information" may include: monthly statements, encounter forms, account printouts and may disclose Medical treatment information. I also authorize the above party to be contacted via phone, if necessary, to discuss my account.

I understand that I am ultimately responsible for adhering to office financial policies and insuring that balances are paid in a timely manner.

Sign _____ Date _____

Patient Name(s) _____

