GUNDERSEN
HEALTH SYSTEM®
1900 South Ave., La Crosse, WI 54601
(608)782-7300 • (800)362-9567

Authorization for Treatment/Payment/Disclosure of Protected Health Information
Tax ID #39-0813416 (Gundersen Lutheran Medical Center, Inc.) Tax ID #39-1028657 (Gundersen Clinic, Ltd.)

1. Patient Information:

   ____ ________________________ ____________________
   Name – Last, First | Medical Record Number | Date of Service

2. The undersigned understands that treatment, emergent, non-emergent, or elective procedure, is/are considered and/or appropriate. The treatment(s) and procedure(s) will be performed by physicians, members of the house staff and employees of the hospital on the Date of Service listed above, or as part of an episode of care including the Date of Service. Authorization is hereby granted for such treatment(s) and procedure(s).

3. To induce Gundersen Clinic, Ltd. and/or Gundersen Lutheran Medical Center, Inc. to render services, the undersigned agrees and authorizes as follows:
   a. I understand that I am financially responsible for the services rendered, or materials and equipment used to the extent that accident insurance or health insurance benefits do not pay my bill. This is a family purpose obligation and our martial assets as well as my individual assets shall be available to satisfy this obligation.
   b. I hereby authorize payment directly to Gundersen for the clinic and/or hospital benefits otherwise payable to me, but not to exceed the clinic or hospital's regular charges for the period of my hospitalization or treatment.
   c. I hereby authorize Gundersen to disclose any medical or other information from my current hospitalization or episode of treatment to my insurance carrier or its agent should it be needed for payment of claims. I understand that if I receive treatment for mental illness, HIV, developmental disabilities, drug or alcohol abuse, these records are included.
   d. I hereby authorize Gundersen to disclose information concerning my diagnosis and treatment to my referring/family doctor as appropriate.

   This authorization may be revoked in writing at any time prior to the disclosure of this information. I understand that this authorization will expire upon the conclusion and settlement of claims for this episode of care. By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorization recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material disclosed. **Copies of records may be obtained with reasonable notice of payment of copying costs.**

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4. Medical Authorization. To the extent that I am eligible for Medicare benefits, by signing this form I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, PLEASE UNDERSTAND THE FOLLOWING: This is a family purpose transaction. The undersigned, to induce Gundersen to render services, obligate our marital assets as well as my individual assets to the satisfaction of this family obligation.

Signature of Patient: ____ **Date:** ______________________________
If signed by a person other than the patient, state relationship and authority to do so.

Patient is: ☐ Minor ☐ Incompetent ☐ Incapacitated ☐ Other (specify): ____

Relationship: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Spouse ☐ Other: ______________________________