GUNDERSEN HEALTH SYSTEM

1900 South Ave., La Crosse, WI 54601
www.gundersenhealth.org
(608)782-7300 • (800)362-9567

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

Patient Information:

Name – Last, First

Date of Service

Date of Birth

Medical Record Number

I hereby authorize Gundersen Lutheran Medical Center, Inc., Gundersen Clinic, Ltd., to provide emergent, non-emergent, or elective procedures, as considered necessary and/or appropriate.

I hereby authorize Gundersen Lutheran Medical Center, Inc., Gundersen Clinic, Ltd. to disclose any medical or other health information 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 AND ALCOHOL ABUSE, THESE RECORDS ARE INCLUDED.

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.

I understand that my signature allows for billing for past and future services provided by Gundersen.

I assign payment directly to Gundersen for benefits otherwise payable to the insured.

A photocopy/facsimile of this authorization shall be as valid as the original, and may be cancelled at any time.

Medicare 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 and 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.

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: _____

Notification: In accordance to state law this is a family purpose obligation and our marital assets as well as my individual assets shall be available to satisfy this obligation.