GUNDERSEN
HEALTH SYSTEM®

Tax ID #39-0813416 (Gundersen Lutheran Medical Center, Inc.)
Tax ID #39-1028657 (Gundersen Clinic, Ltd.)

AUTHORIZATION FOR CONSOLIDATION OF ADULT PATIENT'S ACCOUNTS

Name of Patient: _____

Date of Birth: _____ **Medical Record No:** _____

Name of Guarantor: _____

Health Insurer: _____ **Date:** _____

1. **Consent by Adult Child.** The undersigned patient hereby authorizes Gundersen Clinic, Ltd. and Gundersen Lutheran Medical Center, Inc. (Collectively "Gundersen") to consolidate the patient's clinic and hospital accounts with the accounts of the above-referenced guarantor. The patient understands and agrees that this Authorization permits Gundersen staff to give access to and make verbal and written disclosures of all financial and medical information relating to the account(s) for billing and payment related activities to the above-referenced Guarantor. The patient warrants and represents that s/he is an eligible dependent under the guarantor's health insurance based upon age. The Patient agrees to notify Gundersen immediately upon loss of eligibility for continuing health coverage under the Guarantor's health insurance.

2. **Expiration Date.** This Authorization shall be valid until revoked or until Gundersen becomes aware that patient is no longer covered by the guarantor's health insurance.

3. **No Conditions.** Gundersen may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization. Failure to sign this Authorization will result in the patient being moved to their own guarantor account and receiving the bills for their services.

4. **Re-disclosure**, Gundersen is required under HIPAA to appropriately safeguard your Protected Health Information from unpermitted access, use, and disclosure. This Authorization permits Gundersen to make disclosures to an individual who is not subject to those HIPAA requirements and is not restricted from further disclosure of your information.

5. **This authorization may be revoked by the patient, in writing, at any time by submitting a written revocation request to the Revenue Cycle Department at 1900 South Avenue, La Crosse, WI 54601 Attn: Revenue Integrity, Mailstop NCA3-01.**

Signature of Patient _____ Date:_____