

**BJ'S WHOLESALE CLUB, INC. OPTICAL DEPARTMENT ("BJ'S OPTICAL")  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("AUTHORIZATION")**

Please provide the information below. BJ's Optical is unable to respond to your request without a complete and signed Authorization.

**Patient Name (first, middle, last):** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**INFORMATION COVERED BY THIS AUTHORIZATION**

Entire medical record

Medical records from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Other, please explain: \_\_\_\_\_

**REASON FOR DISCLOSURE**

At the request of the individual

Other, please explain: \_\_\_\_\_

**RECIPIENT(S)**

Name, address, and fax number of the person(s) or entity(ies) to whom BJ's Optical may disclose my information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACKNOWLEDGMENT AND UNDERSTANDING**

I acknowledge and understand that:

- This Authorization may be revoked in accordance with BJ's Optical Notice of Privacy Practices; unless so revoked, this Authorization will remain in effect until BJ's Optical fulfills this request;
- The protected health information disclosed by BJ's Optical in accordance with this Authorization may be (i) redisclosed by the recipient(s), and (ii) no longer be protected by applicable law;
- This Authorization may include disclosure of information related to alcohol/drug abuse, mental health, STD, or HIV/AIDS related treatment only if I initial the applicable line below:  
                  \_\_\_\_\_Alcohol/Drug Treatment      \_\_\_\_\_Mental Health Treatment  
                  \_\_\_\_\_STD Treatment                    \_\_\_\_\_HIV/AIDS Treatment
- My decision to sign or not sign this Authorization will not affect my ability to receive services from BJ's Optical;
- An electronic copy of this Authorization will be as effective as the original copy; and
- I have had an opportunity to ask questions about the disclosure of my protected health information.

**BY SIGNING BELOW, I HEREBY KNOWINGLY AND VOLUNTARILY AUTHORIZE BJ'S OPTICAL TO DISCLOSE MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative's Relationship to Patient: \_\_\_\_\_

*Note to patient representatives: If you are completing this Authorization on behalf of another individual, you must present evidence of your personal representative status.*