AUTHORIZATION OF BJ's WHOLESALE CLUB, INC. TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes: _____

_____

_____

_____

RECIPIENT: Name of person or class of persons to whom **BJ's Wholesale Club, Inc.** (the "Company") may disclose my health information:

_____

_____

_____

Address of the recipient or where my health information should be delivered: _____

_____

_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until _____ __, 20__
☐ Until Company fulfills this request
☐ Until the following event occurs: _____

PURPOSE: I authorize the Company to use or disclose my health information during the term of this Authorization for the following specific purpose(s):

_____

_____

I understand that once Company discloses my health information to the recipient, Company cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Company; except, however, if my treatment at the Company is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Company may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Company's HIPAA Privacy Office at the address listed below. The revocation will be effective immediately upon the Company's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Company in reliance on this Authorization before it received my written notice of revocation.

I may contact the Company's HIPAA Privacy Office by mail at **25 Research Drive, Westborough, Massachusetts 01581**, by telephone at (844) 506-6516 or by email at BJSHPO@bjs.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily, authorize the Company to use or disclose my health information in the manner described above.

_____	_____
Signature of Patient	**Date**

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____	_____	_____
Signature of Authorized Personal Representative	Relationship to Patient	Date