

NATIONAL VISION, INC. REQUEST FOR ACCESS TO DESIGNATED RECORDS

Effective _____ [date], I, _____ [Customer's name], request access to that health information contained in the designated record set that National Vision, Inc. (the "Company") or a business associate of the Company maintains on my behalf and which is described as follows [identify the information to be accessed and the requested time and manner of access as specifically as possible]:

_____ [] *check here if additional pages are attached.*

Please check any of the following boxes if they apply:

I would like a copy of the health information mailed to the following address:

I would like to inspect the health information in your offices.

Other (explain):

I understand that the Company may charge me for, and I agree to pay:

- (1) the reasonable cost of supplies for and labor of copying, and**
- (2) if applicable, postage for mailing the health information.**

Signature

-or-

Signature of Personal Representative of Customer

Date

Relationship of Personal Representative to Customer

[see next page]

[TO BE COMPLETED BY RETAIL ASSOCIATE]

(check one)

- I know the individual making this request.
- I hereby verify the identity of the individual requesting protected health information and the authority of the individual to have access to the protected health information.

Signature of Retail Associate

Store Number

SUBMIT COMPLETED FORM TO:

Privacy Officer
National Vision, Inc.
296 Grayson Highway
Lawrenceville, GA 30045

For National Vision, Inc. Use Only:

Date Received: (MO/DY/YR) ____/____/____

Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED

Patient notified in writing of response to Request on this date: (MO/DY/YR) ____/____/____

Fee charged for fulfilling this Request (if applicable): \$ _____

Name or Initials of Privacy Office Member processing this Request: _____