NATIONAL VISION, INC.
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Effective _____ [date], I, _____ [Customer's name], request that National Vision, Inc. (the "Company") and any business associate of the Company communicate my protected health information by the following alternative means or alternative locations, as specified below:

_____

_____

_____

_____

_____

_____

-or-

_____ _____
Signature of Customer Signature of Personal Representative of Customer

_____ _____
Date Signed Relationship of Personal Representative to Customer

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[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: _____