NATIONAL VISION, INC.
REQUEST FOR RESTRICTIONS

Effective _____ [date], I _____ [Customer's name], request that National Vision, Inc. (the "Company") and any business associate of the Company restrict, in the manner specified below:

- ❑ Uses or disclosures of protected health information about me to carry out treatment, payment, or healthcare operations [specify manner and nature of restriction]:

_____

_____

_____

- ❑ Disclosures to family members and other individuals [specify manner and nature of restriction]:

_____

_____

_____

I understand that the Company is not obligated to grant my request.

_____ **-or-** _____

Signature of Customer

Signature of Personal Representative of Customer

_____ _____

Date Signed

Relationship of Personal Representative to Customer

[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

[see next page]

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: _____