

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

[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: _____