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.

______________________________ Signature of Customer	**-or-**	______________________________ 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

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[see next page]

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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: _________________________________

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