FIRSTSIGHT VISION SERVICES, INC.
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Effective _____ [date], I, _____ [Patient's name], request that FirstSight Vision Services, 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 Patient | Signature of Personal Representative of Patient

_____ _____

Date Signed | Relationship of Personal Representative to Patient

---

[TO BE COMPLETED BY FIRSTSIGHT 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 FirsSight Associate | Date | Store Number

SUBMIT COMPLETED FORM TO:

Privacy Officer
FirstSight Vision Services, Inc.
1202 Monte Vista Avenue
Upland, CA 91786

For FirstSight Vision Services, Inc. Use Only:

Date Received: (MM/DD/YY) _____/_____/_____

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 FirstSight Associate processing this Request: _____