

**FIRSTSIGHT VISION SERVICES, INC.
REQUEST FOR AN ACCOUNTING**

I, _____ [Patient's name], request that FirstSight Vision Services, Inc. (the "Company") provide me with an accounting of all disclosures of my protected health information made by the Company or its business associates (except for disclosures described below) within the following period (not to exceed six years from the date of this request and not for any period before April 14, 2003): _____

I recognize that the Privacy Rule expressly permits the Company not to account for certain disclosures (for example, disclosures to carry out treatment, payment, and healthcare operations), and I expressly exclude all such disclosures from the scope of my request.

METHOD OF DELIVERY

How would you like to receive the accounting? You may request that the accounting be provided to you at the Vision Center or sent to another address by regular mail or electronic mail.

Check one:

AT VISION CENTER _____ BY MAIL _____ BY E-MAIL _____

Mailing Address:

E-mail Address:

POSSIBLE FEES

You are entitled to one free accounting every 12 months. If you have already requested an accounting within the last twelve months, we may charge a reasonable fee to cover the costs of producing any additional accountings you are requesting on this form. We will notify you before any fees are charged, so that you may decide whether to continue with your request, modify your request to reduce the fee, or withdraw your request and pay no fee.

Signature of Patient

-or-

Signature of Personal Representative of Patient

Date Signed

Relationship of Personal Representative to Patient

[see next page]

[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 FirstSight 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: _____