FIRSTSIGHT VISION SERVICES, INC.
REQUEST FOR ACCESS TO DESIGNATED RECORDS

Effective [date], I, _____[Patient's name], request access to that health information contained in the designated record set that FirstSight Vision Services, Inc. (the "Company") or a business associate of the Company maintains on my behalf and which is described as follows [identify the information to be accessed and the requested time and manner of access as specifically as possible]:

_____

_____

_____

_____

[ ] *check here if additional pages are attached.*

Please check any of the following boxes if they apply:

- ☐ I would like a copy of the health information mailed to the following address:

  _____

  _____

- ☐ I would like to inspect the health information in your offices.
- ☐ Other (explain):

  _____

  _____

I understand that the Company may charge me for, and I agree to pay:

1) **the reasonable cost of supplies for and labor of copying, and**
2) **if applicable, postage for mailing the health information.**

_____ **-or-** _____

Signature of Patient — 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: _____