

**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:

Signature of Patient **-or-** _____
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 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: _____