FIRSTSIGHT VISION SERVICES, INC.

FIRSTSIGHT VISION SERVICES, INC.
REQUEST FOR RESTRICTIONS

Effective ____________ [date], I __________________________[Patient's name], request that FirstSight Vision Services, 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.

______________________________	**-or-**	______________________________
Signature of Patient		Signature of Personal Representative of Patient
____________________		______________________________
Date Signed		Relationship of Personal Representative to Patient

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[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

[see next page]

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: ___________________________________