

SPECTOCULAR CONSENT PACKET

Wet-Signature Consent Packet

Subject ID: _____

Patient

DOB

Clinic Patient ID / MRN

Site

Packet date

Consentor

CHECK ALL BOXES on the signature and attestation pages.

WHO SIGNS WHERE - all signature pages are at the END of this packet

Signature page	Page	Who signs
Research ICF - last page of the approved form	p. 13	Patient + Consentor
Medical Release - last page of the approved form	p. 15	Patient
SpectOcular Consent - info + signatures (16-18)	p. 16	Patient + Consentor
Consent-process attestation	p. 17	Consentor

TECHNICIAN SCRIPT - read to the patient:

"We reviewed three documents today: our practice consent, a medical-records release, and the research consent. The signature pages are at the end of this packet. Please check every box, then sign and date wherever you see a blue PATIENT flag. I will sign at the teal STAFF flags. You will receive your own copy of everything."

- Print ONE signing packet for wet signatures - it is filed in the site binder after scanning. The patient's copy can be a second printout OR the emailed full packet, their choice.
- Margin flags mark every ink spot: blue PATIENT » = patient signs, teal STAFF » = staff signs.
- Witness line only if the participant cannot read. Staff countersignature can be added later.

SpectOcular LLC

**Practice Patient Services Consent, HIPAA Authorization,
Medical Records Release, and Communication Authorization**

Version 1.1 | June 2026

Practice / Entity	SpectOcular LLC
Address	11615 Forest Central Drive, Suite 308, Dallas, Texas 75243
Email	info@spectocularhealth.com
Phone	214-233-6170
Fax	214-241-4947

1. Purpose of This Consent

This Practice Patient Services Consent, HIPAA Authorization, Medical Records Release, and Communication Authorization (“Practice Consent”) allows SpectOcular LLC (“SpectOcular”) to create and maintain a patient services record for me and to communicate with me and my healthcare providers for non-research patient services, care coordination, medical-record management, retinal image-review support, administrative services, and other SpectOcular services that I may request or authorize.

This Practice Consent is separate from any research informed consent or research HIPAA authorization that I may be asked to sign for a SpectOcular research study. My decision to sign or not sign this Practice Consent will not affect my medical care, my relationship with my eye care provider, or my ability to participate in any research study.

2. SpectOcular Patient Services Relationship

Separate from any research participation, I authorize SpectOcular to create and maintain a patient services record for me and to contact me by phone, email, text message, mail, or patient portal regarding SpectOcular services, administrative matters, care coordination with my eye care providers, retinal image-review support, medical-record requests, appointment or follow-up communications, and future services that may be available.

I understand and agree that, by signing this Practice Consent, I am establishing a patient services relationship with SpectOcular for the limited purposes of care coordination, communication, medical-record management, retinal image-review support, administrative services, and other SpectOcular services that I may request or authorize.

I understand that SpectOcular does not replace my treating optometrist, ophthalmologist, primary care physician, or other healthcare providers, and that my treating providers remain responsible for my clinical care unless I separately enter into a direct clinical relationship with a SpectOcular-affiliated licensed clinician.

I understand that SpectOcular may provide retinal image-review support, second-opinion support, administrative coordination, or analytics-related services to my treating eye care provider or other

healthcare providers. Any findings or recommendations provided to my healthcare provider are intended to supplement, not replace, the independent clinical judgment of my treating provider.

3. Research Activities Are Separate

I understand that SpectOcular may also conduct research studies involving retinal imaging, clinical data, and artificial intelligence development. Participation in any such research study requires a separate research informed consent and HIPAA authorization.

Signing this Practice Consent does not automatically enroll me in any research study. Likewise, declining this Practice Consent does not prevent me from participating in a research study if I separately sign the required research consent.

I understand that investigational artificial intelligence outputs developed or evaluated by SpectOcular for research purposes will not be used to guide my medical care or be provided directly to me unless and until such use is legally permitted, clinically appropriate, and separately authorized.

4. Authorization to Use and Disclose Protected Health Information

I authorize SpectOcular and its workforce, contractors, vendors, professional consultants, affiliated clinicians, and authorized representatives to use, receive, maintain, and disclose my protected health information ("PHI") as reasonably necessary for the purposes described in this Practice Consent. This authorization applies to past, present, and future/ongoing health information and permits SpectOcular to make initial and repeated requests for longitudinal records and updates from my healthcare providers, pharmacies, laboratories, imaging centers, health systems, health plans, and other authorized sources unless and until I revoke this authorization in writing.

The information that may be used, received, maintained, or disclosed may include, but is not limited to:

- My name, date of birth, address, phone number, email address, and other identifying information;
- Medical history and physician notes;
- Eye care records and retinal or ophthalmic imaging;
- Diagnoses and problem lists;
- Medications;
- Laboratory results;
- Vital signs and other clinical data;
- Cardiac testing, including echocardiograms, stress tests, EKG/ECG reports, or related records;
- Radiology images and reports, including CT, MRI, X-ray, ultrasound, or other imaging records;
- Procedure reports, including colonoscopy, endoscopy, surgery, or other procedure documentation;
- Hospital, clinic, laboratory, pharmacy, and diagnostic testing records;
- Insurance, billing, referral, and scheduling information;
- Any other health information reasonably related to SpectOcular services, care coordination, image-review support, medical-record management, or administrative services.

Sensitive information, including mental health, substance use, HIV-related information, genetic information, reproductive health information, or other specially protected information, may be used or disclosed only where permitted by applicable law and only to the extent necessary for the purposes described in this Practice Consent.

5. Medical Records Release Authorization

I authorize any physician, optometrist, ophthalmologist, retina specialist, primary care physician, hospital, clinic, laboratory, radiology center, imaging center, pharmacy, health system, health plan, diagnostic service provider, or other healthcare provider involved in my care to release my medical records and health information to SpectOcular. This authorization includes longitudinal access to records generated before, on, and after the date I sign this Practice Consent, and it permits SpectOcular to request updated records periodically or as needed for the purposes described in this Practice Consent unless and until I revoke this authorization in writing.

This authorization includes, but is not limited to, the release of:

- Medical history and physician notes;
- Laboratory results;
- Medications, medication lists, pharmacy records, refill history, dispensing history, allergies, and diagnoses;
- Retinal and ophthalmic imaging;
- Optical coherence tomography (OCT), OCT angiography (OCTA), fundus photography, and related image files or reports;
- Radiology images and reports, including CT, MRI, and X-ray;
- Cardiac testing, including echocardiograms, stress tests, EKG/ECG reports, and related cardiac records;
- Procedure reports, including colonoscopy, endoscopy, surgery, and other procedures;
- Vital signs and other clinical data;
- Hospital discharge summaries, consultation notes, and specialist reports;
- Other relevant health information.

The purpose of this medical records release is to allow SpectOcular to provide patient services, care coordination, retinal image-review support, administrative services, healthcare analytics, medical-record management, longitudinal health record review, and related services that I request or authorize. If I separately sign a research informed consent and research HIPAA authorization, information obtained under that separate research authorization may also be used for the research purposes described in that research consent.

6. Persons or Entities Authorized to Receive or Use My Information

I authorize my information to be disclosed to, received by, or used by the following persons or entities, as reasonably necessary for the purposes described in this Practice Consent:

- SpectOcular LLC;
- SpectOcular workforce members, contractors, professional consultants, and authorized representatives;
- SpectOcular-affiliated clinicians or image reviewers;
- My treating optometrist, ophthalmologist, retina specialist, primary care physician, or other healthcare providers;
- Healthcare providers, laboratories, imaging centers, hospitals, or health systems involved in my care;
- Business associates, vendors, technology providers, cloud-storage providers, electronic health record vendors, medical-record retrieval vendors, and other service providers working with SpectOcular under appropriate privacy and security arrangements;

- Health plans, payers, or other entities when necessary for authorized clinical, administrative, billing, coordination, or operational purposes.

7. Electronic Communication Authorization

I authorize SpectOcular and its representatives to contact me using the contact information I provide, including by:

- Telephone call;
- Voicemail;
- Text message;
- Email;
- Mail;
- Patient portal or other electronic platform.

Communications may include administrative messages, appointment or follow-up communications, care-coordination communications, medical-record requests, retinal image-review support communications, service updates, and information about SpectOcular services that may be available.

I understand that email and text messaging may not be fully secure and may involve some risk that my information could be seen by others. I still authorize SpectOcular to communicate with me in these ways unless I later request a different communication method.

I understand that I may opt out of non-essential text messages or certain types of communications by notifying SpectOcular in writing or by following any opt-out instructions provided in the message. I understand that opting out of certain communications may affect SpectOcular's ability to provide certain services or coordinate records.

8. Use of Technology, EHR Systems, Cloud Storage, and Data Management Tools

I understand that SpectOcular may use electronic health record systems, practice management systems, secure cloud-storage systems, image-storage systems, data-management platforms, secure file-transfer tools, e-signature tools, and other technology platforms to provide services and manage my information.

SpectOcular may store and process my information in secure, HIPAA-compliant or HIPAA-capable systems and may use vendors or business associates to support these systems. SpectOcular will implement reasonable administrative, technical, and physical safeguards designed to protect my information.

9. Retinal Image Review and Clinical Responsibility

I understand that SpectOcular may provide retinal image-review support or second-opinion support to my treating eye care provider. SpectOcular's review may include review of retinal images, OCT images, OCTA images, fundus photographs, imaging reports, clinical history, or related records.

Unless I separately enter into a direct clinical relationship with a SpectOcular-affiliated licensed clinician, I understand that my treating optometrist, ophthalmologist, primary care physician, or other healthcare provider remains responsible for my clinical care, diagnosis, treatment, referral decisions, and communication of clinical findings to me.

I understand that SpectOcular's services are not a substitute for emergency care. If I have an urgent medical or eye problem, I should contact my treating healthcare provider, call 911, or seek emergency care.

10. Artificial Intelligence and Analytics Limitation

I understand that SpectOcular may develop or evaluate artificial intelligence, machine learning, analytics, or related technologies. I understand that investigational artificial intelligence outputs developed or evaluated by SpectOcular for research purposes will not be used to guide my medical care or be provided directly to me unless and until such use is legally permitted, clinically appropriate, and separately authorized.

Any clinical services provided to me or to my healthcare provider will be provided under applicable legal, professional, and regulatory requirements.

11. Redisclosure

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations, depending on who receives the information and the purpose of the disclosure. SpectOcular will use reasonable safeguards and, where required, appropriate agreements to protect my information.

12. Expiration

This Practice Consent and authorization will remain in effect unless and until I revoke it in writing, unless a shorter period is required by applicable law. While this authorization remains in effect, it permits access to longitudinal information, including future records and updates created after the date of signature, from the providers, pharmacies, health systems, laboratories, imaging centers, health plans, and other entities described above.

13. Revocation

I understand that I may revoke this Practice Consent and authorization at any time by submitting a written request to SpectOcular at the contact information listed above.

I understand that revocation will not affect any use or disclosure of information that occurred before SpectOcular received and processed my revocation request. I also understand that SpectOcular may retain information as required or permitted by law, including for documentation, compliance, billing, audit, legal, regulatory, clinical, or business-record purposes.

14. Voluntary Authorization

I understand that signing this Practice Consent is voluntary. I understand that my decision to sign or not sign this Practice Consent will not affect my right to receive medical care from my treating healthcare providers and will not affect my ability to participate in a research study if I separately complete the required research consent.

I understand that if I do not sign this Practice Consent, SpectOcular may be unable to create a patient services record for me, communicate with me outside a research protocol, obtain my outside medical records for non-research services, or provide certain patient services or coordination activities.

15. Patient Acknowledgment

For electronic webpage signatures, I understand that checking the consent box, typing my name, drawing or uploading my signature, and submitting the web form will have the same effect as signing this Practice Consent by hand, to the extent permitted by applicable law. The webpage may automatically populate my signature, printed name, date, time, and related submission information into this document.

By signing below, I acknowledge that:

- I have read this Practice Consent or had it read to me;
- I have had the opportunity to ask questions;
- I understand that this Practice Consent is separate from any research consent;
- I authorize SpectOcular to create and maintain a patient services record for me;
- I authorize SpectOcular to contact me as described above;
- I authorize the use and disclosure of my health information as described above;
- I authorize my healthcare providers, pharmacies, laboratories, imaging centers, health systems, health plans, and related entities to release my medical records and longitudinal health information to SpectOcular as described above.

PARTICIPANT INFORMED CONSENT FORM AND AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

STUDY TITLE: Prospective Evaluation of Retinal Imaging and Clinical Data for Prediction of Ocular and Systemic Disease

STUDY DOCTOR: Sai H Chavala, MD

STUDY SITE: SpectOcular
11615 Forest Central Drive, Suite 308
Dallas, TX 75243

TELEPHONE: 214-233-6170

SPONSOR: SpectOcular, LLC

You are being asked to participate in a research study. Your participation in this research study is strictly voluntary, meaning that you may or may not choose to take part. To decide whether or not you want to be part of this research, the purpose, procedures, risks and possible benefits of the study are described in this form so that you can make an informed decision. This process is known as informed consent. This form also explains how your medical information will be used and who may see it. You may have a copy of this form to review at your leisure or to ask advice from others.

The study investigator is the owner, CEO and sole employee of SpectOcular LLC, the study sponsor. The study investigator may make money if the study goes well. There are no plans to share this with people who take part in this study. Please ask the research staff if you have any questions.

The study doctor or study staff will answer any questions you may have about this form or about the study. Please read this document carefully and do not hesitate to ask anything about this information. After reading the consent form, if you would like to participate, you will be asked to sign this form. You will be given a signed copy of your consent form to take home and keep for your records.

Purpose of the Study

You are being asked to participate in a research study to determine whether images of the eye (retina) and related health information can be used to better understand and predict overall health, including heart and brain conditions, as well as detect certain eye diseases. About 5,000 people aged 18 years and older will participate in this research study. Your participation in this study will last for 3 years.

Procedures

If you agree to participate, images of your eye taken as part of your routine clinical care may be used for research. Your medical history and other health information may also be reviewed and obtained from your medical doctors and other healthcare providers involved in your care. You will not undergo any additional imaging or procedures for research purposes.

Risks

The primary risk is loss of confidentiality of your personal health information. No additional medical or physical risks beyond routine care are expected.

Benefits

You will not receive direct benefit from participation. This research may help improve future detection of eye and diseases that affect the whole body.

Alternatives to Participation

This study is for research purposes only so your alternative is to not participate in this study.

New Information

You will be informed in a timely manner if new information that may influence your willingness to continue participation in the study becomes available.

Costs and Compensation

There is no cost to you for participation in this study. You will not receive any compensation for participation in this study.

Artificial Intelligence Disclosure

Your data may be used to develop artificial intelligence (AI) models. These models are for research purposes only and will not be used to guide your medical care.

Data Ownership and Commercial Use

By participating, you agree that your de-identified data, including images, clinical information, and any derived data, may be used for research, development, and potential commercial purposes. You will not receive financial compensation from any future commercial use of this data.

Voluntary Participation

Participation in this study is voluntary. You may choose not to participate or may withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled, and without affecting your medical care.

You may withdraw from the study at any time by notifying the study team using the contact information provided below either:

- In writing (for example, email or mailed notice), or
- By contacting the study team by phone

If you choose to withdraw, no new information will be collected about you for research purposes after the date of withdrawal. The effective date of withdrawal will be the date the study team receives your request.

However, information and retinal images that have already been collected and used as part of the research, including data that has been de-identified or incorporated into aggregated datasets, analyses, or machine learning models, cannot be removed or withdrawn.

Data that has been de-identified and integrated into research datasets or analytical models may continue to be used for research purposes and cannot be linked back to you.

Your participation may be stopped without your consent by the study doctor or the FDA for any reason. For example, your participation may be stopped:

- if it is deemed to be in the best interest of your health and welfare.

Employees as Research Subjects

Regarding employees who participate in the study, there will be no privilege given for participating in this research study. Likewise, there will be no penalty or drawbacks associated with not participating. Participation is strictly voluntary and will not be tied to any preferential treatment or promotion within the company.

Confidentiality and Authorization to Collect, Use and Disclose Your Medical Information

As a part of this research, records that contain information or data about you and your health may be collected and used. These records may identify you and will be kept as confidential as possible. To the extent permitted by applicable laws and regulations, the records identifying you will not be made publicly available.

Under the privacy laws, you have the right to decide who can use your protected health information (called PHI). By signing this form, you authorize the use and disclosure of your protected health information ("PHI") for research purposes as described in this study.

The information that may be used or disclosed includes:

- Retinal images obtained during your clinical care
- Medical history
- Diagnoses
- Medications
- Laboratory results

- Vital signs
- Imaging studies (including radiology such as CT, MRI, and X-ray)
- Cardiac testing (including echocardiograms and stress tests)
- Procedure reports (including colonoscopy, endoscopy, and other procedures)
- Other relevant health information

This information may be obtained from:

- Your eye care providers
- Your primary care physician
- Other healthcare providers involved in your care
- Hospitals, laboratories, and diagnostic service providers

The study team will know your identity; however, your records will be labeled with a code that is randomly assigned to you. The research staff are the only people who will have this code and its key.

The following groups may review and use your study information. They may review your study information to make sure that it is correct. They may also review your information to make sure that the study is being conducted properly.

- SpectOcular LLC and its research team
- Sterling Institutional Review Board (IRB)
- Authorized research personnel and collaborators
- Other doctors, health care professionals or research staff who are involved in the study

Your study information may be released to the groups listed above. If your study information is reviewed by these people, they may need to see your entire medical record; it is possible that your Social Security number may be included in the records reviewed. Because of this, it cannot be assured that your confidentiality will always be protected. It is possible that your information will be shared (re-disclosed) in a way that it would no longer be protected. However, this access to your records will be granted without violating your confidentiality to the extent permitted by applicable laws and regulations. By signing this form, you are authorizing this access to your records.

The results of the study, including your information, may also be presented at meetings or in articles written about the study (publications). If the results of the study (including your research or health information) are published, your identity will remain confidential.

The purpose of this authorization is to conduct research, including the development and validation of analytical models and artificial intelligence technologies related to eye and whole body health.

This authorization does not have an expiration date.

You may revoke (take away) this authorization at any time by contacting the study team in writing. However, any information already collected and used as part of the research, including data that

has been de-identified or incorporated into datasets, analyses, or machine learning models, cannot be withdrawn.

As a rule, the researchers will not continue to use or disclose information about you, but will keep it secure until it is destroyed. Sometimes, it may be necessary for information about you to continue to be used or disclosed, even after you have canceled your permission or the study is over.

Examples of reasons for this include:

- To avoid losing study results that have already included your information.
- To provide limited information for research, education, or other activities. (This information would not include your name, social security number, or anything else that could let others know who you are.)
- To help government officials or the Institutional Review Board make sure that the study was conducted properly.

Information disclosed as part of this research may be subject to redisclosure and may no longer be protected under federal privacy regulations.

Contact Information

If you have questions about this study, please contact the study team at SpectOcular:

SpectOcular LLC
11615 Forest Central Drive, Suite 308
Dallas, Texas 75243
E-mail: info@spectocularhealth.com
Phone: 214-233-6170
Fax: 214-241-4947

If you have questions regarding your rights as a research participant, or if you have questions, concerns, complaints about the research, would like information, or would like to offer input, you may contact the Sterling Institutional Review Board Regulatory Department at telephone number 1-888-636-1062 (toll free) or info@sterlingirb.com.

Participant Statement and Authorization

I have read or have had read to me the Participant Informed Consent Form and Authorization to Use and Disclose Medical Information and I agree to participate voluntarily in this study. I give my permission to the study doctor to use and disclose my protected health information as described in this consent form.

I will receive a signed copy of this form.

All my questions have been answered.

I have not waived any of my legal rights by signing this document.

Printed Name of Participant

Signature of Participant

Date

Printed Name of Person Explaining Consent

Signature of Person Explaining Consent

Date

Signature of Witness

Date

*A witness is not required unless the participant is unable to read (such as blind or illiterate). If a witness is present, however, the witness must observe the entire informed consent process, including participant signature.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize any physician, hospital, clinic, laboratory, radiology center, or other healthcare provider to release my medical records to Dr. Sai Chavala, MD, SpectOcular LLC, for research and healthcare analytics purposes.

Patient Information

Name: _____

Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Information to be Released

All of the following information is requested and may be released, including but not limited to Medical history and physician notes, Laboratory results, Medications and diagnoses, Retinal and ophthalmic imaging, Radiology images and reports (e.g., CT, MRI, X-ray), Cardiac testing (e.g., echocardiogram, stress tests), Procedure reports (e.g., colonoscopy, endoscopy), and Vital signs and other clinical data. Sensitive information including mental health, substance use, and HIV-related information where permitted by law

Recipient

SpectOcular LLC
11615 Forest Central Drive, Suite 308
Dallas, Texas 75243
E-mail: info@spectocularhealth.com

Purpose

The purpose of this authorization is for research, data analysis, and development of healthcare algorithms.

Redisclosure

Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal privacy regulations.

Expiration

This authorization does not expire unless revoked in writing.

Revocation

I understand I may revoke this authorization at any time in writing, except to the extent that action has already been taken.

PATIENT »

Patient Signature

Patient Signature: _____

Printed Name: _____

Date: _____

SpectOcular Patient Consent - Sections 16-18

Sections 16-17 are auto-filled from enrollment data entry - signatures below.

16. Patient Information

First Name	Last Name	Date of Birth
Street Address	City / State / ZIP	
Phone	Email	Preferred Contact
Clinic Patient ID / MRN		

17. Primary Care and Other Healthcare Providers

Primary Care Physician (name, phone, address)

Pharmacy (name, phone, address)

18. Signatures

By signing below, I acknowledge that I have read this Practice Consent or had it read to me; I had the opportunity to ask questions; I understand this Practice Consent is separate from any research consent; and I authorize the use and disclosure of my information as described in this Practice Consent. This page may be completed by wet or typed/electronic signature.

PATIENT » Patient Signature

Date:

Wet signature

Printed Name of Patient

Signature Date

STAFF » Consensor Signature - person obtaining consent / verifying identity

Date:

Wet signature

Consensor Printed Name

Consensor Role

Consent Process Attestation - Research Consent / HIPAA Authorization

This page documents the consent process for the Research Consent / HIPAA Authorization executed today, together with the Medical Release and SpectOcular Patient Services Consent contained in this packet.

Consentor / person obtaining consent	Role
Identification type reviewed	Consent process date/time

☐ I verified the participant's identity using official identification or a clinic-approved identity source, and no photograph, scan, copy, ID number, barcode, or image of the identification was retained. The participant had the opportunity to ask questions and/or contact SpectOcular research personnel before signing; voluntary participation was reinforced and clinical care is not affected by the decision; and the participant's signature applies to the packet documents executed today.

Notes:

STAFF »

Consentor Signature - person obtaining consent

Wet signature

Date:

OPTIONAL - Research staff review / countersignature (may be completed later)

Signature

Date: