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)
- ❑ 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 Signature

Patient Signature: _____

Date: _____