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;

16. Patient Information

Patient Name	{{patient_name}}
Date of Birth	{{patient_dob}}
Street Address	{{patient_street_address}}
City, State, ZIP	{{patient_city_state_zip}}
Phone Number	{{patient_phone}}
Email Address	{{patient_email}}
Preferred Method of Contact	{{preferred_contact_methods}} [phone/text/email/mail/portal]

17. Primary Care and Other Healthcare Providers

Primary Care Physician / Clinic	{{primary_care_provider_name}}
Pharmacy Name	{{pharmacy_name}}
Pharmacy Address	{{pharmacy_address}}
Pharmacy Phone / Fax	{{pharmacy_phone_fax}}
Lab Provider	{{other_providers_health_systems_labs}}

18. Signatures

Patient Electronic Signature / Typed Name	{{patient_signature}}
Signature Date	{{signature_date}}
Signature Time / Time Zone	{{signature_time_timezone}}
Printed Name of Patient	{{patient_printed_name}}
Consent Checkbox Confirmation	{{consent_checkbox_confirmation}}
Representative Name, if applicable	{{representative_name}}
Representative Relationship / Authority	{{representative_relationship_authority}}
Representative Electronic Signature	{{representative_signature}}

Representative Signature Date	{{representative_signature_date}}
SpectOcular / Practice Representative, if applicable	{{spectocular_representative_name}}
SpectOcular Representative Signature	{{spectocular_representative_signature}}
SpectOcular Representative Signature Date	{{spectocular_representative_signature_date}}
Web Form Submission ID	{{webform_submission_id}}
Web Form Submission Timestamp	{{webform_submission_timestamp}}

Internal Use Only

SpectOcular Patient ID	{{spectocular_patient_id}}
Athena ID	{{athena_id}}
Nextech ID	{{nextech_id}}
OD Location / Site	{{od_location_site}}
Research Study ID, if separately consented	{{research_study_id}}
Research Consent Status	{{research_consent_status}}
Practice Consent Status	{{practice_consent_status}}
Medical Release Status	{{medical_release_status}}
Notes	{{internal_notes}}