

Patient Data Collection Consent Form

I, **Kasunika Karunarathne** [P678], hereby consent to the collection of my personal health information by OCR Tool for the purpose of data collection and analysis.

The personal health information that will be collected includes:

- Demographic information such as name, date of birth, address, phone number, and email address
- Medical history and diagnosis information
- Treatment and medication information
- Laboratory and diagnostic test results
- Intraoral and Extraoral photographs

I understand that this information will be used for research purposes and may be shared with other healthcare providers or researchers for improving patient care. I understand my personal information will be kept confidential and will not be disclosed to any unauthorized individuals or organizations.

I hereby give my consent for the collection and use of my personal health information and oral images for data collection and analysis purposes.

Signature:

A handwritten signature in black ink, appearing to be 'Kasunika Karunarathne', written in a cursive style.

Signature: Kasunika Karunarathne
Date: 18/09/2024