

## Patient Consent Form

### To whom it may concern:

I DEEPA. A, hereby verify that I have received information about my proposed treatment. I have discussed my treatment with Dr. SATISH at the KIMS HEALTH CARE Hospital located in THIRUVANANTHAPURAM and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternative treatment options, the risks of the recommended treatment, and I am satisfied with the descriptions. I have been asked by 'Right To Live' an initiative of Kote Foundation to produce copies of ID proof, BPL card, medical reports and any other related documents in assisting me to provide financial assistance for my medical treatment.

### MEDIA RELEASE CONSENT:

I hereby give my permission for Right To Live and/or its representatives to use photographs, audio tape recordings, letters, information or videotape of my child or myself and to use our names, information, these images or voice recordings in publications, slides, videotapes, motion pictures or on the Internet.

I understand they will be used to inform families, volunteers, media and the general public about the Right To Live and its programs, services or events.

I wish to proceed with the recommended treatment with my full knowledge and consent. I hereby understand that 'Right to Live', an initiative of Kote Foundation is only a facilitator in the treatment and is not responsible for the treatment, or the outcome of the treatment, in any way.

I am immensely grateful to Right to Live for facilitating this treatment, which otherwise would have been difficult for me to access.

I hereby certify that I have read and fully understood the above.

#### Patient:

Name: DEEPA. A  
Signed: [Signature]  
Date: 19.07.2023

#### Parent or Guardian:

Name: DEEPA. A  
Signed: [Signature]  
Date: 19.07.2023

#### **Right To Live - (A Kote Foundation Initiative)**

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