



CHICAGO ENT

a division of

ADVANCED CENTER FOR SPECIALTY CARE

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I hereby authorize: Dr. Michael Friedman
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To release information from the medical record of:

Name of Patient: _____ DOB _____

Address: _____

Telephone Number: _____

TO:

Phone#: _____ Fax#: _____

This information will be used for the purpose of:

Only the information specified below may be released:

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This consent will automatically expire at the earliest date below as specified.

After 90 Days

Otherwise expressly stated Date _____

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Patient Signature or Legal Guardian

Date