CHICAGO SLEEP CENTER

A Division of CHICAGO ENT

I hereby authorize: Dr. Michael Friedman, Medical Director
3000 N. Halsted, Suite 400
Chicago, IL 60657

To release information from the medical record of:

Name of Patient: ____________________________ D.O.B._______

Address: ____

____

Telephone Number: __________________________

To:____

____

____

This information will be used for the purpose of:

____

Only the information specified below may be released:

____

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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

EAR, NOSE & THROAT

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Adam Levy, MD

Kathryn Colman, MD

Sarah Felt, PA-C

ALLERGY

Ayesha Siddiqi, MD

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