

**Steven A. Gold, M.D. L.L.C.**

**Release of Records**

I, \_\_\_\_\_ (patient), hereby authorize

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

the disclosure of the following protected health information:

- All Medical Records
- Letters
- Progress Notes
- Allergy Test Results
- Other Lab Test Results
- Spirograms
- Immunotherapy History (Including Components of Extracts)
- Consultant's Reports
- Other: \_\_\_\_\_

My protected health information may be disclosed to:

**Steven A. Gold, M.D.**  
**36 West Main Street**  
**Suite 203**  
**Freehold, New Jersey 07728**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority