

**CLAIRE M. KARAM, Ph.D.**  
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**RELEASE OF INFORMATION**

TO: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip  
\_\_\_\_\_  
Telephone Number

I, \_\_\_\_\_ (your name) hereby give my permission  
to CLAIRE M. KARAM, Ph.D. to obtain the following information for the  
purpose of evaluation and treatment:

Medical records \_\_\_\_\_  
Evaluations \_\_\_\_\_  
Course of treatment \_\_\_\_\_  
Other \_\_\_\_\_

Signed \_\_\_\_\_ Dated \_\_\_\_\_  
(your name)