

CLAIRE M. KARAM, Ph.D.
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303/393-8794
Fax # 303/388-3896

RELEASE OF INFORMATION

TO: (Person sending release 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: (check all that apply)

Medical records _____

Evaluations _____

Course of treatment _____

Other _____

Signed _____ Dated _____
(your name)