CENTER FOR
ANXIETY & DEPRESSION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO DR DUNNER

I authorize_____
to release protected health information which may include information relating to mental health, alcohol and substance abuse, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)—to

David L. Dunner, MD
400 Island Corporate Center
7525 SE 24th Street
Mercer Island, WA 98040

Phone: 206-230-0330
Fax: 206-230-0336

_____ _____
Name Date

_____
Witness

Other identifying information about me:

Address

Phone
Hospital or clinic number

Date of birth