

**AUTHORIZATION TO RELEASE INFORMATION**

**SHELLY (Michelle) WINEMILLER, LMFT – M.A. in ADLERIAN PSYCHOTHERAPY**

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Rochester, MN 55902

Psychiatric       Psychological       Addiction treatment       Medical  
 All Records       Psychiatric Evaluation       Psychological assessment  
 School Records       Chemical Health Assessment       Telephone consultation

Purpose of disclosure:  Continuity of care    [ ] \_\_\_\_\_

I understand that my records may be protected under the federal regulation governing confidentiality of alcohol and Drug Abuse Client Records, 42 CFR Part. 2, and cannot be disclosed without my written consent unless otherwise provided for in regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

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I \_\_\_\_\_ (client) hereby authorize **Shelly Winemiller, MA, LMFT**

To Exchange with       To Obtain from       To Release to

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

the information checked above.

Date: \_\_\_\_\_      Signature \_\_\_\_\_

Witness \_\_\_\_\_