CHURCH ASSISTANCE PROGRAM
AUTHORIZATION TO RELEASE INFORMATION

I authorize representatives of **Groff & Associates, LLC** and ________________________ (*Church's Name)* to exchange information regarding my health care sessions, including treatment plans and progress reports, for the purpose of receiving monetary assistance from _______________________________*(Church's Name)*.

Signature: ____ Date: ______________
(Client's or Responsible Person First and Last Name)

Printed Name: _______________________________________
(Client's or Responsible Person First and Last Name)

Please mail or fax this form to:

Groff & Associates, LLC
7425 East 86th Street
Indianapolis, IN 46256-1207
Phone: 317-474-6448 x101
Fax: 317-468-9905

ATTN: Sally Groff, MA, LMFT, Clinical Director

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