



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 x102
Fax: 317-468-9905

ATTN: Operations Director