



## 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 86<sup>th</sup> Street  
Indianapolis, IN 46256-1207  
**Phone:** 317-474-6448 x102  
**Fax:** 317-468-9905

**ATTN:** Operations Director