

AUTHORIZATION TO RELEASE INFORMATION

NOTICE: By signing below: (1) You will allow CGFNS/ICHP to disclose confidential, personal, private information about you and your file at CGFNS/ICHP to the person designated below; (2) You will give up the right to receive duplicate information from CGFNS/ICHP; and (3) You release and indemnify CGFNS/ICHP, its members, trustees, officers and employees from any liability, losses, damages claims of any type arising out of actions taken by CGFNS/ICHP in reliance upon this Authorization.

This authorization will remain valid for two years from the date written below (or if non-from the date this authorization is received by CGFNS/ICHP)

You may revoke this Authorization in written at any time which will be effective on and after CGFNS/ICHP receives your written revocation by regular mail or courier at the headquarters office in Philadelphia, PA USA-faxed, electronic mail, voice mail or oral revocations will not be effective under any circumstances.

AUTHORIZATION: I authorize CGFNS/ICHP to release to the below named Authorized Recipient any and all information about me and my application/order, the results of any credentials review, examination or test, and any other information in or relating to my file at CGFNS/ICHP.

CGFNS/ICHP ID No: _____(if known)

Date of Birth: _____

Signature: _____

Print Name: _____

Date: _____

AUTHORIZED RECIPIENT:

Print Name : **Abhijit Bhattacharjee**
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