

**EMPLOYEE'S CONSENT AND AUTHORIZATION TO RELEASE MEDICAL AND/OR DENTAL RECORDS**

This form authorizes CCSI, our Third Party Administrator (TPA), to obtain all medical and/or dental records of the claimant.

The injured worker needs to fill out and sign this form. Please have someone witness their signature.

When form is completed, please mail to the following address:

Contract Claims Services, Inc.  
P.O.Box 541328  
Dallas, Tx 75354-1328

