

**Dr. Gary W. Beavers, D.D.S.**  
**224 High House Road, Suite 200**  
**Cary, NC 27513**  
**Phone: (919) 467-7717**  
**Fax: (919) 467-0912**

**Authorization to Transfer Dental Records**

Patient's Name:

\_\_\_\_\_

Date of Birth:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

Authorization for Release: I hereby authorize:

\_\_\_\_\_

(Dr.'s Name or Facility Name)

to release and deliver dental records and current x-rays to:

Gary W. Beavers, D.D.S.  
224 High House Road, Suite 200  
Cary, NC 27513

Email: [staff@gbeaversdds.com](mailto:staff@gbeaversdds.com)

Patient or Parent's Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_