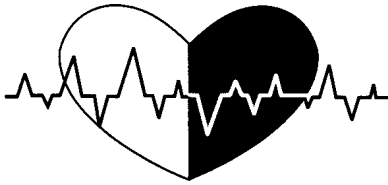


CARDIOVASCULAR CENTER OF SARASOTA

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- Life Member of the Doctors Mayo Society

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Physician's Name

Address

City, State, and Zip Code

Phone Number

I hereby request my Medical records be released to:

Mahfouz El Shahawy, M.D.
1950 Arlington Street, Suite 300
Sarasota, FL 34239

Patient's Name (Please Print)

Patient's Signature

Date

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