Patient Request to Amend Records

Tallahassee Neurological Clinic, P.A.
Medical Records Department
1401 Centerville Road Suite 300
Tallahassee, FL 32308
(850) 558-1275
(850) 558-1282 FAX

I hereby request the Tallahassee Neurological Clinic, P.A. (the "Clinic") to amend my medical record as follows:

- □ Separate document attached.
- □ Add the notation below:

I am requesting the amendment described above for the following reason:

I understand that the Clinic may deny my request under certain conditions specified in the privacy regulations issued by the U.S. Department of Health and Human Services. I understand that the Clinic will act on my request within 60 days after it receives it, as required by the privacy regulations.

Patient Name:	
Name:	Relationship:
Signature:	Date:

OFFICE USE ONLY		
Reviewed by:	Initials:	Date:
Decision: □ Approved □ Denied □ Response	Decision Notification Sent:	
Response approved by:		Date: