Patient Request to Amend Records

Tallahassee Neurological Clinic, P.A.
1401 Centerville Road, Suite 300
Tallahassee, FL 32308
850-877-5115 - phone
850-656-3645 - fax

I hereby request 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:

_____

_____

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_____

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 received 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: