

# DENT

NEUROLOGIC INSTITUTE

President: Vernice E. Bates, MD  
Medical Director: Laszlo L. Mechtler, MD, FAAN

Bela Ajtai, MD, PhD  
Traci Aladeen, PharmD  
J Aubrey Bottoms, Ph.D., ABPP-CN  
Horacio A. Capote, MD  
Marc S. Frost, MD  
Fran M. Gengo, PharmD  
Sanjay Gupta, MD

Ashraf Henry, MD  
Tomas H. Holmlund, MD  
Shivang Joshi, MD, MPH, RPh  
Anupama M. Kale, MD  
Xiuli Li, MD  
Jennifer McVige, MD, MA  
Bennett H. Myers, MD

Thomas Pfiffner, MD  
Mohammad M. Qasaymeh, MD, MS  
Michelle Rainka, PharmD, CCRP  
Luisa Rojas, MD  
Nicolas P. Saikali, MD  
Lixin Zhang, MD, PhD  
Joseph V. Fritz, PhD, CEO

## Request to Amend Patient Records

### Dent Neurologic Institute

Patient Name: \_\_\_\_\_ Provider: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Street City, State Zip

I request that the following medical record information be amended (*attached a separate document if needed*):

Reason for the requested change:

\_\_\_\_\_  
Patient Signature or Personal Representative Date

*Office Use Only*

- We hereby accept this request.  
 We hereby deny this request.

\_\_\_\_\_  
Practice Representative (Type/Print)

\_\_\_\_\_  
Practice Representative Signature

\_\_\_\_\_  
Date

I understand that you will review my request to amend records and provide a written determination within 60 days. I also understand that Federal Regulations may not allow information to be amended under certain circumstances specified by HIPPA Privacy Rules 45 CFR 164.526. If the request is denied, I understand that I may submit a written statement explaining my disagreement with the decision, which statement will be included in my medical records, along with any response from the practice.

If the amendment is approved, in whole or in part, I understand the practice will make the appropriate amendment to my records and also is required to make reasonable efforts to inform and provide the amendment within a reasonable time to other entities or practices who received the PHI.

Please mail all completed requests to: Attn: Medical Records Department  
Dent Neurologic Institute  
3980 Sheridan Dr.  
Amherst, NY 14226

You may also fax requests to the Medical Records Department at 716-250-2045

Amherst • Buffalo • Orchard Park

P: 716-250-2000 | F: 716-250-2045 | www.dentinstitute.com

DIAGNOSTICS & SERVICES

MRI • CT • X-Ray • Botox • Doppler/TCD • EEG • EMG • Infusion • Neuropsychology • Sleep Studies • Ultrasound • TMS • Vestibular Testing