Merging Patient Records Request Form

Participant Organization Name

Patient record to be merged:

Patient Name (First and Last) Patient DOB

Patient MRN

Patient record merging into (this will be the remaining record):

Patient Name (First and Last) Patient DOB

Patient MRN

Signature Date

THIS FORM CAN BE FAXED TO 315-407-0053 OR EMAILED VIA DIRECT MAIL TO SUPPORT@HIEMAIL.HEALTHECONNECTIONS.ORG