Patient Record Merge Request Form

Use this form to request a merge if you find duplicate patient records in HealtheConnections Health Information Exchange (HIE). **All fields are required.**

Patient Record to be Merged

(This record will be removed after the merge)

First Name: _____

Last Name: _____

Date of Birth (MM/DD/YYYY): _____

MRN: _____

Patient Record to Retain

(This record will remain in the system)

First Name: _____

Last Name: _____

Date of Birth (MM/DD/YYYY): _____

MRN: _____

Requesting Organization Information

Organization Name: _____

Requestor Name: _____

Title: _____

Phone Number: _____

Email: _____

Requestor Signature: _____

Date: _____

Submission Instructions

Return this form to HealtheConnections using one of the secure methods below.

- **Encrypted Email**: Send to support@healtheconnections.org
- **Fax**: Send to 315-407-0053
- **Secure Messaging**: If you use this system, send to support@hiemail.healtheconnections.org.

Important: All Protected Health Information (PHI) must be sent in encrypted format.

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