Merging Patient Records Request Form

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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