Merging Patient Records Request Form

Participating 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 1-315-407-0053 or emailed via Direct Mail to support@healtheconnections.org.

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