

# Request to Change Demographic Information

You can update your address, phone number, email address in these ways:

- + When you register at check-in
- + In person at any OhioHealth facility that provides patient care. **NOTE: You may be asked for identification.**
- + By mail:
  - Fill out this form
  - Make a copy of your government issued ID
  - Mail the form and the copy of your ID to: **Health Information Management/Medical Records, 3535 Olentangy River Road, Columbus, OH 43214**

Due to the potential for fraud, OhioHealth employees cannot update your information over the phone or by email. We apologize in advance for this inconvenience. If you have any questions about this form, please contact Health Information Management at OhioHealth at **(614) 566-5444**.

## SECTION 1. PATIENT INFORMATION

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Phone number where we can reach you if we have questions.

## SECTION 2. WHAT IS YOUR CURRENT INFORMATION?

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

## SECTION 3. WHAT INFORMATION NEEDS UPDATED/CHANGED?

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

## SECTION 4. WHO IS MAKING THIS REQUEST? SELECT ONLY ONE.

- I am the patient
- I am the Patient's parent, and the patient is under the age of 18 years old.
- I am the Patient's legal guardian. I have attached the relevant legal documents, such as the Power of Attorney, to support this statement.

\_\_\_\_\_  
Signature (hand signature required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

**OH Associate OPID:** \_\_\_\_\_

\_\_\_\_\_  
If not the Patient, relationship to the patient

**Date:** \_\_\_\_\_



**REQUEST TO CHANGE  
DEMOGRAPHIC INFORMATION**

PATIENT IDENTIFICATION LABEL