Petition for Modification Form - Change Person Information

Return completed forms (one PDF per patient) to the MCIR Help Desk

MDHHS-MCIRHelp@michigan.gov

This form is for non-public (healthcare provider, hospital, pharmacy, and local health department) use only.
Members of the public must use the MCIR Public Request to Change Information form.

Verify the person's legal documentation to confirm the correct information. DO NOT SEND LEGAL DOCUMENTATION.

Change or Correct Person's Information

- Complete Sections: 1, 2, 3, 4a, 4b, and 5. If there is also a duplicate record, enter the duplicate in Section 4c.
- For adoptions, enter the birth record/original name in 4a and the new name in 4b. Add the MCIR ID if there is an existing record with the new name. If there are 3+ records, enter additional duplicates in 4c.

Duplicate Records

- Complete Sections: 1, 2, 3, 4c, and 5. Section 4a and 4b can be left blank unless you are also changing or correcting person information. Enter additional MCIR IDs into the notes for more than 3 duplicates.
- Check the box to indicate the correct record to be kept during the duplicate record merge process. If neither of the existing duplicate records are correct (first/middle/last name and DOB), enter corrections in Section 4b.

***Sections 1-3 and Section 5 are REQUIRED for ALL requests. Failure to do so will delay the processing of this request.**

SECTION 1 – Requestor's Information (REQUIRED)

Organization Name OR MCIR Site ID Number*	Email Address*	DOCUMENTATION VERIFIED? *
		◯ Birth Certificate
Full Name - Person Completing Form*	Phone Number*	◯ Driver's License or State ID
	Ext:	◯ Legal/Court Order/Adoption Papers
		◯ Passport

SECTION 2 – Request Information (REQUIRED)

Requestor Type*	Change Requested (check all that apply) *		Notes/Comments
☐ Healthcare Provider	**Correction:**	**Legal Name Change:**	
☐ Pharmacy	☐ Date of Birth	☐ Elective	
☐ Hospital	☐ Sex	☐ Marriage/Divorce	
☐ LHD	☐ Spelling	☐ Adoption	
	☐ Duplicate Record		

SECTION 3 - Responsible Party Contact Information (REQUIRED FOR ALL REQUESTS. Minor under 18 cannot be the responsible party):

Name*:			Relationship: ☐ Patient ☐ Parent ☐ Legal Guardian
Address*:			Phone Number:
City*:	State*:	Zip*:	County*:

SECTION 4 – Record Information (4a and 4b *OR* 4c are REQUIRED)

4a. Person's Information AS IT CURRENTLY APPEARS IN MCIR

Last Name	First Name	Middle Name	Date of Birth	MCIR ID	Sex
					☐ M ☐ F

4b. Person's CORRECT Information (Use " to indicate if the field is unchanged from 4a)

Last Name	First Name	Middle Name	Date of Birth	MCIR ID	Sex
					☐ M ☐ F

4c. Duplicate Records

Check the box to indicate the correct record to be kept during the duplicate record merge process.
If none of the existing duplicate records are correct, enter corrections above in 4b.

Last Name	First Name	Middle Name	Date of Birth	MCIR ID	Sex	CORRECT?
					☐ M ☐ F	☐
Last Name	First Name	Middle Name	Date of Birth	MCIR ID	Sex	CORRECT?
					☐ M ☐ F	☐
Last Name	First Name	Middle Name	Date of Birth	MCIR ID	Sex	CORRECT?
					☐ M ☐ F	☐

SECTION 5 – SIGNATURE REQUIRED (E-SIGNATURES ACCEPTED)

By signing below, I verify that I have retained legal documentation to support the changes requested above.

Signature*: _____ **Date*:**