



eternalHealth

Member Authorization: API Data Sharing

Risk Disclosure: Data shared may no longer be protected by HIPAA once received by third party applications (app).

Member Information

Member Name:

Member ID:

Email Address:

Phone Number:

Vendor Information

App Name:

Developer:

URL:

Data Sharing (check all that apply)

- | | |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Claims | <input type="checkbox"/> Clinical |
| <input type="checkbox"/> Enrollment | <input type="checkbox"/> Provider |
| <input type="checkbox"/> Formulary | <input type="checkbox"/> Other: |

Duration

- | | | |
|--|---------------------------------|---------------------------------|
| <input type="checkbox"/> Until Revoked | <input type="checkbox"/> 1 Year | <input type="checkbox"/> Other: |
|--|---------------------------------|---------------------------------|

Sensitive Data Acknowledgment: Data disclosed may include mental health, SUD, HIV, genetic, reproductive health unless restricted.

List Restrictions:

Member/ Representative Signature:

By typing my name below, I agree that this constitutes my electronic signature and has the same legal effect as a handwritten signature. I certify that the information provided is accurate and that I am the member or an authorized representative with authority to submit this request.

Printed Name (Typed Signature):

Relationship to Member (if applicable):

Date:

Email Completed Form to: interoperability@eternalhealth.com