eternalHealth

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Member API Opt-Out Request

Member Information

Member Name:

Member ID:

Email Address:

Phone Number:

Opt-Out Request

I request that eternalHealth disable third-party app access to my health information via API.

Effective Date:

I understand that this action would stop future sharing but does not restrict data already disclosed.

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