

GeeseMed EHR

Version 7.1.41

§170.315(b)(10) Electronic Health Information export- Documentation

This document describes the details for §170.315(b)(10) Electronic Health Information export

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Overview:

GeeseMed EHR meets the certification criterion **§170.315(b)(10) Electronic Health Information export** by implementing the CCD Export for Single Patient and Bulk Export. This helps the clinical users to generate the Clinical Care Document for a single patient or for a group of patients in accordance with the standards specified in § 170.205(a)(6) - HL7 CDA® R2 IG: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 4.1 - US Realm and Health Information Technology (ASTP/ONC) HTI-1 final rule to use USCDIv3 (United States Core Data for Interoperability)

To achieve this, we have implemented,

- Single Patient Export and Bulk Patient Export in the CCD format which can be printed in Adobe PDF format.
- Ability to download the Clinical notes on demand and can be printed in Adobe PDF format.

a. Single Patient Export

Step 1: Select Date range and click on **Create and view CCD** button

Real Time

Batch Export

CCD Result

From Date

mm/dd/yyyy

To Date

09/30/2025

Create & View CCD

Print

Export CCD

Neighborhood Physicians Practice

Patient First Name	Alice
Patient Last Name	Newman
Patient Previous Name	Alicia
Sex	Female
Birth Sex	Female
Date of birth	May 1, 1970
Race	White
Granual Race	
Ethnicity	Not Hispanic or Latino
Preferred language	English
Home Address	Primary Home: 1357 Amber ,DrBeaverton, OR 97006, US
Previous Address	
Telephone Number	Tel (Primary Home): tel:+1(555)-723-1544 Tel (Mobile): tel:+1(555)-777-1234 Tel: mailto:alicenewman_123@yopmail.com

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Step 2: User will be able to view CCD in readable format.

Step 3: click Export button and select the path on the computer to save the data. The exported zip file will have the CCDA readable format and xml file.

b. Bulk Patient Export

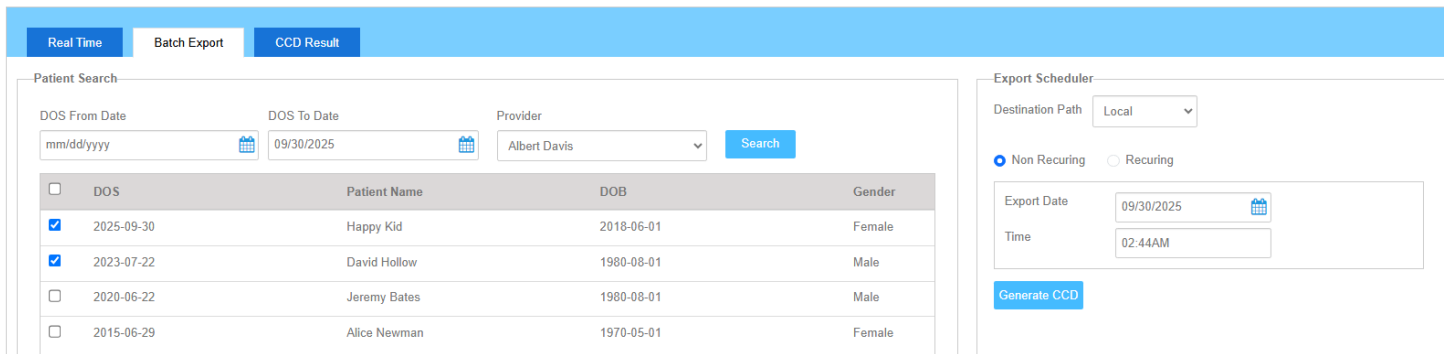
Step1: Select date range, Provider and click on **Search** button.

Step2: Select the list of patients for which Data Export to be perform

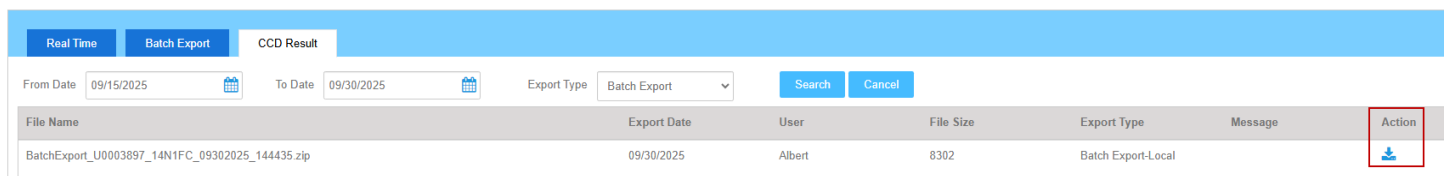
Step3: Select exported .zip file download destination path. Either LOCAL computer path or DIRECT MAIL.

Step4: Select non-recurring or recurring option and enter export date and time

Step5: Click **Generate CCD** button. This will give message “CCD generation is in progress, after a while Go to CCD Result section to download Exported CCD .Zip file.



Step 6: Click download arrow icon to download Batch export .zip file. This file contains readable CCD files and xml of selected patients.



File Name	Export Date	User	File Size	Export Type	Message	Action
BatchExport_U0003897_14N1FC_09302025_144435.zip	09/30/2025	Albert	8302	Batch Export-Local		

The exported zip file will have the CCDA readable format xml and other clinical data as PDF documents.

 **BatchExport.html**
 **David Hollow_09302025_144447.html**
 **David Hollow_09302025_144447.xml**
 **Happy kid_09302025_144445.html**
 **Happy kid_09302025_144445.xml**

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Sections in CCD:

Standard Referenced:

§ 170.205(a)(6) - HL7 CDA® R2 IG: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 4.1 - US Realm and Health Information Technology (ASTP/ONC) HTI-1 final rule to use USCDIv3 (United States Core Data for Interoperability)

Data Elements	Description
Patient Demographics/Information	
Patient Name	
Patient Previous Name	
Sex	
Birth Sex	
Date of Birth	
Race	
Ethnicity	
Preferred Language	
Phone Number	
Patient Home Address	
Patient Previous Address	
Patient Death Date	The patient's date of death if recorded in the patient's information
Care team members	
Care giver name	Provider / Staff
Specialty	
Provider's name and office contact information	
Assigned Author	Provider
Assigned Author telecom	Provider phone number
Represented Organization Name	Location/Facility name
Represented Organization Address	Location/Facility address
Represented Organization telecom	Location/Facility phone no#
Participant	
Associated Person Name	Next of kin name
Associated Entity Code	Next of kin relationship with patient
Associated Entity Address	Next of kin address
Associated Entity telecom	Next of kin telephone no
Encounter Diagnosis (Template ID: 2.16.840.1.113883.10.20.22.2.22.1)	
Encounter Code	Diagnosis code

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Encounter Diagnosis	Diagnosis/Problem name
Encounter Diagnosis Date	Diagnosis date
Encounter Diagnosis Status	Diagnosis Status
Immunizations (Template ID: 2.16.840.1.113883.10.20.22.2.2.1)	
Vaccine Name	
Date	Administration date
Status	
Notes	
Treatment Plan (Template ID: 2.16.840.1.113883.10.20.22.2.10)	
Planned Observation	Future Appointments, lab orders, medication orders and diagnostic orders
Planned Date	Plan date
SDOH intervention	SDOH intervention from Screening intervention section
Social History (Template ID: 2.16.840.1.113883.10.20.22.2.17)	
Social History Observation	Smoking Status, Basic occupation, Gender identity, Sexual orientation, Tribal affiliation, Pregnancy status, SDOH assessment
Description	Description
Dates Observed	Date
Problems (Template ID: 2.16.840.1.113883.10.20.22.2.5.1)	
Problem	
Status	
Date Onset	
Medications (Template ID: 2.16.840.1.113883.10.20.22.2.1.1)	
Medication	
Direction	SIG
Start date	
End Date	
Medication Allergies (Template ID: 2.16.840.1.113883.10.20.22.2.6.1)	
Substance	
Reaction	
Severity	
Status	
Date	
Vitals (Template ID: 2.16.840.1.113883.10.20.22.2.4.1)	
Observation	
Observation Date	
Laboratory Tests	

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Test Code	
Test Name	
Order Date	
Ordering Provider	
Laboratory Information	
Lab Name	
Lab Address	
Test Report Date	
Test Performed	
Specimen Source	
Laboratory Results (Template ID: 2.16.840.1.113883.10.20.22.2.3.1)	
Result date	
ref. range	
Observation	
Observation Date/Time	
Clinical Tests and Clinical Test Reports	The patient's clinical tests, which include non-imaging or non-laboratory tests performed.
Goal (Template ID: 2.16.840.1.113883.10.20.22.2.60)	
Goal Description	
Date	
SDOH Goal	
Procedures (Template ID: 2.16.840.1.113883.10.20.22.2.7.1)	
Procedures	
Date	
Reason for Referral (Template ID: 1.3.6.1.4.1.19376.1.5.3.1.3.1)	
Referral To	
Reason for Referral	
Referral Diagnosis	
Medical Equipment (Template ID: 2.16.840.1.113883.10.20.22.2.23)	
Implanted Device name / ID	
Cognitive Status (Template ID: 2.16.840.1.113883.10.20.22.2.56)	
Assessment	
Assessment Date	
Functional Status (Template ID: 2.16.840.1.113883.10.20.22.4.66)	
Assessment	
Assessment Date	

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Disability Status	
Health Concern (Template ID: 2.16.840.1.113883.10.20.22.2.58)	
Patient Stated Health Concern	
SDOH Health Concern	
Date	
Payer (2.16.840.1.113883.10.20.22.2.18)	
Payer Name	
Group Name	
Member ID	
Subscriber ID / Policy Holder	
Subscriber Relation to Patient	
Effective date	

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