

## 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   To Date  

Create & View CCD
Print
Export CCD

#### Neighborhood Physicians Practice

<b>Patient First Name</b>	Alice
<b>Patient Last Name</b>	Newman
<b>Patient Previous Name</b>	Alicia
<b>Sex</b>	Female
<b>Birth Sex</b>	Female
<b>Date of birth</b>	May 1, 1970
<b>Race</b>	White
<b>Granual Race</b>	
<b>Ethnicity</b>	Not Hispanic or Latino
<b>Preferred language</b>	English
<b>Home Address</b>	Primary Home: 1357 Amber ,DrBeaverton, OR 97006, US
<b>Previous Address</b>	
<b>Telephone Number</b>	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

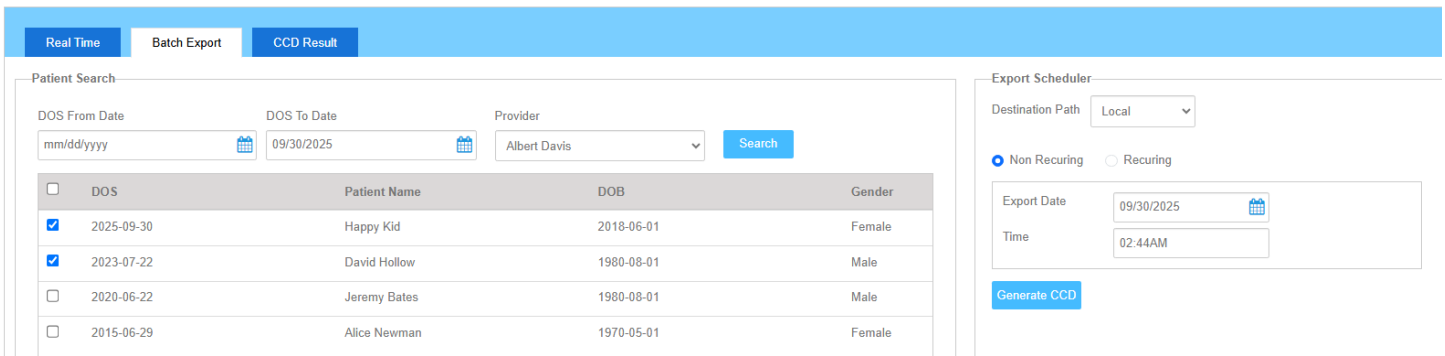
Step1: Select date range, Provider and click on **Search** button.

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.

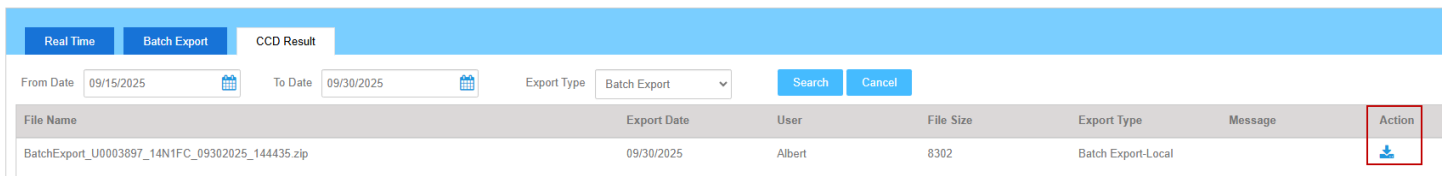
Step4: Select non-recurring or recurring option and enter export date and time


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.



DOS	Patient Name	DOB	Gender	
<input checked="" type="checkbox"/>	2025-09-30	Happy Kid	2018-06-01	Female
<input checked="" type="checkbox"/>	2023-07-22	David Hollow	1980-08-01	Male
<input type="checkbox"/>	2020-06-22	Jeremy Bates	1980-08-01	Male
<input type="checkbox"/>	2015-06-29	Alice Newman	1970-05-01	Female

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)(4) HL7® Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015

Data Elements		Description
<b>Patient Demographics/Information</b>		
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
<b>Care team members</b>		
Care giver name	Provider / Staff	
Specialty		
<b>Provider's name and office contact information</b>		
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#	
<b>Participant</b>		
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	
<b>Encounter Diagnosis (Template ID: 2.16.840.1.113883.10.20.22.2.22.1)</b>		

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

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<b>Laboratory Tests</b>	
Test Code	
Test Name	
Order Date	
Ordering Provider	
<b>Laboratory Information</b>	
Lab Name	
Lab Address	
Test Report Date	
Test Performed	
Specimen Source	
<b>Laboratory Results (Template ID: 2.16.840.1.113883.10.20.22.2.3.1)</b>	
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.
<b>Goal (Template ID: 2.16.840.1.113883.10.20.22.2.60)</b>	
Goal Description	
Date	
SDOH Goal	
<b>Procedures (Template ID: 2.16.840.1.113883.10.20.22.2.7.1)</b>	
Procedures	
Date	
<b>Reason for Referral (Template ID: 1.3.6.1.4.1.19376.1.5.3.1.3.1)</b>	
Referral To	
Reason for Referral	
Referral Diagnosis	
<b>Medical Equipment (Template ID: 2.16.840.1.113883.10.20.22.2.23)</b>	
Implanted Device name / ID	
<b>Cognitive Status (Template ID: 2.16.840.1.113883.10.20.22.2.56)</b>	
Assessment	
Assessment Date	
<b>Functional Status (Template ID: 2.16.840.1.113883.10.20.22.4.66)</b>	
Assessment	

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

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