met all applicable certification criteria adopted by the Secretary; or

(2) A combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.

Complete EHR means EHR technology that has been developed to meet, at a minimum, all applicable certification criteria adopted by the Secretary.

Disclosure is defined as it is in 45 CFR 160.103.

EHR Module means any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary.

Human readable format means a format that enables a human to read and easily comprehend the information presented to him or her regardless of the method of presentation.

Implementation specification means specific requirements or instructions for implementing a standard.

Qualified EHR means an electronic record of health-related information on an individual that:

(1) Includes patient demographic and clinical health information, such as medical history and problem lists; and

(2) Has the capacity:
   (i) To provide clinical decision support;
   (ii) To support physician order entry;
   (iii) To capture and query information relevant to health care quality; and
   (iv) To exchange electronic health information with, and integrate such information from other sources.

Standard means a technical, functional, or performance-based rule, condition, requirement, or specification that stipulates instructions, fields, codes, data, materials, characteristics, or actions.

§ 170.210 Standards for health information technology to protect electronic health information created, maintained, and exchanged.

The Secretary adopts the following standards to protect electronic health information created, maintained, and exchanged:


(2) Exchange. Any encrypted and integrity protected link.

(b) Record actions related to electronic health information. The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which action(s) occurred and by whom must also be recorded.

(c) Verification that electronic health information has not been altered in transit. Standard. A hashing algorithm with


The Secretary adopts the following code sets, terminology, and nomenclature as the vocabulary standards for the purpose of representing electronic health information:

(a) Problems—(1) Standard. The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.


(b) Procedures—(1) Standard. The code set specified at 45 CFR 162.1002(a)(2).

(2) Standard. The code set specified at 45 CFR 162.1002(a)(5).

(c) Laboratory test results. Standard. Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory (incorporated by reference in §170.299).

(d) Medications. Standard. Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.
