**Sec. 170.314 2014 Edition electronic health record certification criteria.**

1. *Patient engagement.*
	1. *View, download, and transmit to 3rd party.*
		1. EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f).
			1. *View.* Electronically view in accordance with the standard adopted at § 170.204(a) [Web Accessibility Standard], at a minimum, the following data:
				1. The Common MU Data Set (which should be in their English (i.e., non- coded) representation if they associate with a vocabulary/code set).
				2. *Ambulatory setting only.* Provider’s name and office contact information.
				3. *Inpatient setting only.* Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.
			2. *Download.*
				1. Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) [HL7 Consolidated CDA] that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):

*Ambulatory setting only.* All of the data specified in paragraph (e)(1)(i)(A)(*1*) and (*2*) of this section. [Common MU Data Set plus provider information]

*Inpatient setting only.* All of the data specified in paragraphs (e)(1)(i)(A)(*1*) and (*3*) of this section. [Common MU Data Set plus discharge information]

* + - * 1. *Inpatient setting only.* Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section).
			1. *Transmit to third party.*
				1. Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(*1*) of this section in accordance with the standard specified in § 170.202(a) [ONC Applicability Statement for Secure Health Transport (“Direct” protocol)].
				2. *Inpatient setting only.* Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in § 170.202(a) [ONC Applicability Statement for Secure Health Transport (“Direct” protocol)].
		1. *Activity history log.*
			1. When electronic health information is viewed, downloaded, or transmitted to a third party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient:
				1. The action(s) (i.e., view, download, transmission) that occurred;
				2. The date and time each action occurred in accordance with the standard specified at § 170.210(g) [Network Time Protocol (NTP)]; and
				3. The user who took the action.
			2. EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.
	1. *Ambulatory setting only—clinical summary.*
		1. *Create.* Enable a user to create a clinical summary for a patient in human readable format and formatted according to the standards adopted at § 170.205(a)(3) [HL7 Consolidated CDA].
		2. *Customization.* Enable a user to customize the data included in the clinical summary.
		3. *Minimum data from which to select.* EHR technology must permit a user to select, at a minimum, the following data when creating a clinical summary:
			1. Common MU Data Set (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set)
			2. The provider’s name and office contact information; date and location of visit; reason for visit; immunizations and/or medications administered during the visit; diagnostic tests pending; clinical instructions; future appointments; referrals to other providers; future scheduled tests; and recommended patient decision aids.
	2. *Ambulatory setting only—secure messaging.* Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures:
		1. Both the patient (or authorized representative) and EHR technology user are authenticated; and
		2. The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f). [FIPS Pub 140-2, Annex A]