RecordSync

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Providers can use **RecordSync** to comprehensively review their patients' clinical history, including previous encounters, diagnoses, lab results, allergies, medications, immunizations, and other treatments. By querying trusted data sources across different healthcare systems, **RecordSync** pulls relevant patient records and care summaries directly into DrChrono, ensuring you have all the insights you need to make confident care decisions.

> 💡 Eligible clinicians can attest to the Merit-based Incentive Payment System (MIPS) Promoting Interoperability (PI) performance category for the Health Information Exchange (HIE) requirement by participating in the RecordSync bi-directional exchange.

DrChrono is integrated with Surescripts Record Locator & Exchange (RLE), a health information exchange. Surescripts' RLE service is a critical component that helps EHR integrators access and participate in Carequality, a national health data exchange framework. It is a bidirectional integration to exchange data in a hub-and-spoke model for requesters/responders within the framework. RecordSync shares real-time data with Carequality, but only if the requester has the same patient and is connected to Carequality.

RLE retrieves records using the HL7® FHIR® standard transactions, ultimately allowing documents to be merged or saved to the patient chart.

Setup

Set up permissions

Providers or staff members must set up permissions to use **RecordSync**.

1. Select **Account** > **Staff Permissions**.

2. Select **View**.

   The permissions window opens.

3. Select **Edit Permissions**.

4. Select the **Access RecordSync** checkbox and then select **Save Permissions**.
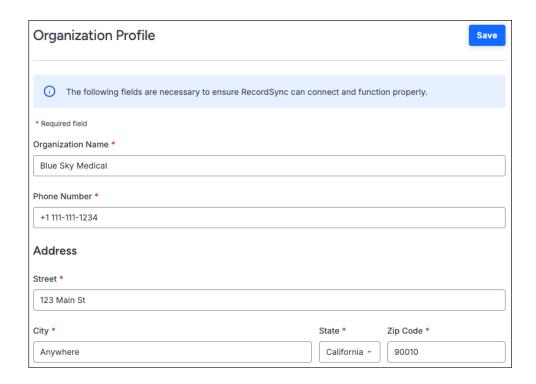
Set up your practice's organization profile

You must set up your practice's organization profile to use **RecordSync**.

1. Select **Account** > **Organization Profile**.

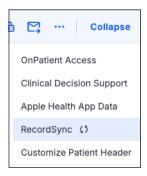   The text boxes automatically pull in information from the following sources:
   - **Organization name: Account** > **Account Settings** > **Medical Billing** > **Practice Official Name**
   - **Phone number and address: Account** > **Offices**

2. Select **Save**.

Retrieve clinical documents

1. In the **Patient Header**, select **More actions** (three dots) ... and then select **RecordSync**.

The **RecordSync & Consent** side panel opens. Once you turn on consent, **RecordSync** starts gathering patient information, which may take several minutes. While the search is in progress, you can close the side panel and continue working on other tasks. A message appears in the lower left corner once the process is complete.

2. Turn the **Record Locator & Exchange Consent** toggle switch on.

If this is your first time using **RecordSync**, the "Adding Your Organization" message appears. When the search is successful, the results appear in the **Record List**.

> 💡 You perform all actions within the side panel. Select a breadcrumb link (top left corner) to go to a previous side panel.

Record List

Multiple filters, search, and sort options exist. Once records are queried, they are stored for 30 days. A new query is automatically triggered after 30 days or upon manual refresh (select **Refresh Records**).

Record List actions

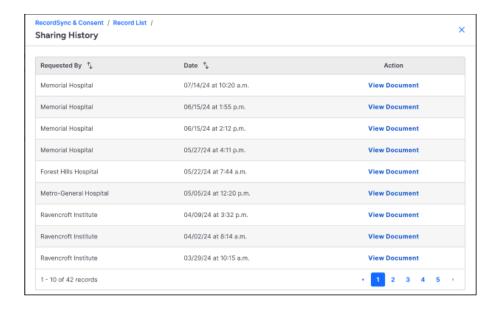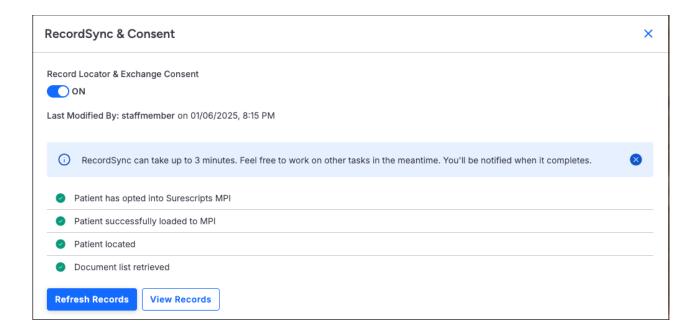| Task	Action
Open the **Sharing History** side panel to review a comprehensive record of document requests made for your patient, including the requester and each transaction date. The side panel also shows documents previously retrieved from external practices for continuity of care. In either case, you can view the shared/retrieved document.	Select **Sharing History**.
Open the document from within the **Sharing History** side panel.	Select **View Document**.
Manually refresh the **Record List** page.	Select **Refresh Records**.
Open the document.	Select **View Document** 🔍.
Import a document.	Select **Import Document** ⬇.
Import a document from within the document.	Select ⬇ **Import** .
Reconcile a document.	Select **Reconcile**.

Document statuses

Status	Description
Available	The document hasn't been retrieved from the external organization.
Error	The document has an issue
Importing	Actively importing the document to start the reconciliation process.
Imported	The document is waiting in the reconciliation queue. If it's not a CCD, it has been imported into the patient's chart in **Documents**. Select **Reconcile** to continue the reconciliation process.
Retrieving	Actively retrieving the document from the external organization.
Retrieved	The document has been retrieved and is available to view, download, or import.
Reconciled	The CCD document data elements have been reconciled into the patient chart.

RecordSync & Consent

> ℹ️ Before turning on **RecordSync** for your practice, be aware that participation in this HIE service requires explicit patient consent. To ensure compliance with federal and state privacy regulations, your practice must include specific language in your patient consent forms authorizing participation in an HIE. Failure to update your consent documentation accordingly may result in noncompliance and prevent the successful use of **RecordSync**. We strongly recommend reviewing your current consent process with your legal or compliance team before activating **RecordSync**.

You can perform the following actions on the **RecordSync & Consent** side panel:

- Turn on or off **RecordSync** consent
- Manually refresh the **Record List**
- View the **Record List**

Imported clinical documents

Imported clinical documents are uploaded to the patient chart (**Documents** > **Uploaded Documents**).

Reconcile clinical data

Consolidated clinical document architecture (C-CDA) reconciliation matches information from a C-CDA file with a patient's electronic health record. This process can automatically start to reconcile problems, medications, and allergies and merge this data with the patient chart.

1. Once a CCD has been successfully imported, the reconciliation process automatically begins. If the process doesn't start, select **Reconcile**. You can also select **Reconcile** when you view an imported CCD.

The page to preview the clinical document opens.

Preview This Document Before Uploading to the Patient Record!

Import Clinical Record:

Transition of Care	[▾]	
Date	[ ]	Date of document, necessary to put this document in the patient's timeline.
Description	[ ]	Description of document.
Is structured data	☑	If true, is lab result and should be automatically added to patient lab result sets after finalizing. For C-CDA it will import medications, allergies and problems.
Lab result processed	☐	If true, lab has been processed and should not be reprocessed.
Type of document	[C-CDA — Consolidated Clinical Document Architect ▾]	Optional Description of document.

[Cancel] [Finalize File] [Finalize File & Start Reconciliation]

2. Do one of the following:

   - To import the document to the patient chart and reconcile the clinical data later, select **Finalize File**. See Continue reconciliation.

   - To reconcile the clinical data now, select **Finalize & Start Reconciliation**. See Finalize and start reconciliation.

Finalize and start reconciliation

You can begin the reconciliation process by finalizing which problem, allergy, and medication data to merge into the patient chart. The problems, allergies, and medications in the C-CDA file appear below those currently in the patient chart.

> ℹ The following steps describe the procedure for problem data, but also apply to allergies and medications.

1. Select the checkboxes for the problems you want to add to the patient chart.

2. **(Optional)** Select **Preview Finalized Problems** to view the patient's problem list, which includes existing and newly added problems.

3. Select **Confirm** to import the selected problems to the patient chart. You can also select **Confirm** from the **Preview Finalized Problem List** page.

Current Patient Chart - Problem

Problem	Code System	ICD-CM Code	SNOMED	Status	Date Changed	Date Created	Edited By
			No results				

C-CDA File - Problem

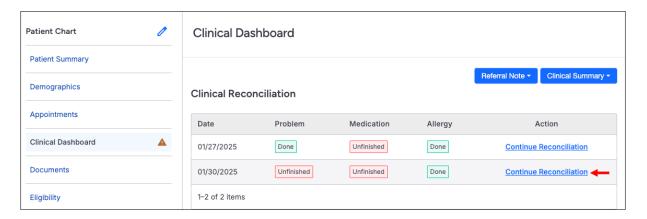|	Problem	Code System	ICD-CM Code	SNOMED	Status	Date Changed	Date Created	Edited By
☐	Acute urticaria	ICD-10		402408009	Active	08/23/2019	01/30/2025	None
☑	Chronic idiopathic urticaria	ICD-10		302162004	Active	09/09/2019	01/30/2025	None
☐	Idiopathic urticaria	ICD-10		42265009	Active	06/21/2022	01/30/2025	None
☐	Urticaria	ICD-10		126485001	Active	08/19/2020	01/30/2025	None
☑	Allergy to mold	ICD-10		419474003	Active	07/10/2018	01/30/2025	None
☑	Allergy to animal dander	ICD-10		232347008	Active	07/10/2018	01/30/2025	None
☐	Mild intermittent asthma	ICD-10		427679007	Active	05/05/2020	01/30/2025	None
☐	Mild persistent asthma	ICD-10		426979002	Active	03/17/2020	01/30/2025	None
☐	History of calculus of kidney	ICD-10		429025008	Active	05/10/2018	01/30/2025	None
☐	Type 2 diabetes mellitus	ICD-10		44054006	Active	10/22/2019	01/30/2025	None

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By clicking "Confirm", you are merging patient data to your chart. If you miss something, you can reupload the CCDA file again and make changes.

Confirm   **Preview Finalized Problems**

A success message appears confirming you have finalized reconciliation. All patient data has been successfully merged into the patient chart.

Continue reconciliation

1. On the **Clinical Dashboard**, select **Continue Reconciliation**.

The problems, allergies, and medications in the C-CDA file appear below the problems, allergies, and medications currently in the patient chart.

> ℹ️ The following steps describe the procedure for problem data, and also apply to allergies and medications.

2. Continue with step 1 in the finalize and start reconciliation procedure.