

CERTIFIED ELECTRONIC HEALTH RECORDS SPECIALIST (CEHRS) PRACTICE EXAM (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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1. What does the suffix "-ectomy" refer to?

- A. Process of recording
- B. Process of measurement
- C. Excision
- D. Deficient

2. What is a hairline fracture?

- A. A fracture involving complete break of the bone
- B. A minor fracture with a thin line that does not go fully through
- C. A fracture that causes bones to overlap
- D. A fracture that completely separates the bone into two parts

3. What is the main purpose of clinical vocabularies?

- A. To create visual representations of patient data
- B. To automate the billing process
- C. To provide a set of common definitions for medical terms
- D. To enhance collaboration among healthcare providers

4. How many codes are used in ICD-10-CM for diagnosis?

- A. 60,000
- B. 100,000
- C. 120,000
- D. 150,000

5. Which term best describes the act of lowering the foot?

- A. Plantar flexion
- B. Dorsiflexion
- C. Abduction
- D. Adduction

6. Which term refers to a small collection of clear fluid commonly seen in blisters?

- A. Wheal
- B. Macule
- C. Vesicle
- D. Fissure

- 7. What term describes a structure located above another structure?**
- A. Inferior
 - B. Superior
 - C. Medial
 - D. Lateral
- 8. What describes internet-based, tethered access to personal health records (PHR)?**
- A. Access through a web application with user authentication
 - B. Access granted by an organization like insurance or healthcare providers
 - C. Access that ensures complete privacy and security
 - D. Access limited to individuals without organizational support
- 9. What is the primary function of the integumentary system?**
- A. Nutrition absorption
 - B. Production of blood cells
 - C. Protection
 - D. Movement assistance
- 10. What does the prefix "pre-" signify?**
- A. Excision
 - B. Before
 - C. Deficient, below
 - D. Process of measurement

Answers

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1. C
2. B
3. C
4. C
5. A
6. C
7. B
8. B
9. C
10. B

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Explanations

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1. What does the suffix "-ectomy" refer to?

- A. Process of recording
- B. Process of measurement
- C. Excision**
- D. Deficient

The suffix "-ectomy" refers to the surgical removal or excision of a part of the body. This term is derived from the Greek word "ektome," meaning "a cutting out." It is commonly used in medical terminology to describe procedures such as appendectomy (removal of the appendix), cholecystectomy (removal of the gallbladder), and hysterectomy (removal of the uterus). In each of these cases, the use of "-ectomy" indicates that a specific organ or tissue has been surgically excised. This understanding is crucial for health information management and medical documentation, as it allows professionals to accurately communicate about surgical procedures and the conditions they address.

2. What is a hairline fracture?

- A. A fracture involving complete break of the bone
- B. A minor fracture with a thin line that does not go fully through**
- C. A fracture that causes bones to overlap
- D. A fracture that completely separates the bone into two parts

A hairline fracture is characterized as a minor fracture that presents a thin line on the bone. This type of fracture does not extend fully through the bone and typically results from stress or overuse rather than a traumatic injury. It is often difficult to detect on standard X-rays, making diagnosis challenging without additional imaging or follow-up. In contrast, other types of fractures involve more significant disruptions to the integrity of the bone. A complete break of the bone signifies a more severe injury where the bone is entirely separated into two parts, which is not the case for a hairline fracture. Similarly, fractures that cause bones to overlap indicate a more complex break, likely contributing to misalignment, which hairline fractures do not present. Understanding these distinctions is crucial for accurate diagnosis and appropriate treatment in clinical practice.

3. What is the main purpose of clinical vocabularies?

- A. To create visual representations of patient data
- B. To automate the billing process
- C. To provide a set of common definitions for medical terms**
- D. To enhance collaboration among healthcare providers

The primary purpose of clinical vocabularies is to provide a standardized set of definitions for medical terms. This standardization is crucial in healthcare as it ensures that all healthcare professionals are using the same language when documenting patient care, which leads to improved communication and reduced misunderstandings among providers. By having common definitions, clinical vocabularies facilitate accurate documentation, data sharing, and interoperability between different health information systems. When healthcare providers document and communicate about diagnoses, treatment plans, and clinical findings, using a consistent language helps ensure that everyone on the care team understands the patient's condition and the care provided. This common understanding is vital for coordinating care, enhancing patient safety, and improving healthcare outcomes. The other options pertain to important aspects of healthcare but do not directly capture the main role of clinical vocabularies. While creating visual representations can aid in understanding patient data, it is not the main goal of clinical vocabularies. Automating the billing process is more related to coding systems rather than the definitions of clinical terms. Enhancing collaboration among providers is certainly a benefit of having a common vocabulary, but the core purpose remains in providing standardized definitions that enhance clarity and understanding in clinical discussions.

4. How many codes are used in ICD-10-CM for diagnosis?

- A. 60,000
- B. 100,000
- C. 120,000**
- D. 150,000

The correct answer is based on the current structure of the ICD-10-CM codes, which encompasses a comprehensive range of medical diagnoses. The ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) consists of approximately 70,000 distinct codes. However, with variations in coding practices and the inclusion of new codes over time, the total count can approach around 120,000 when considering different combinations and additional specifications that are possible within the code set. This significant number reflects the meticulous detail necessary in classifying a vast array of diseases, conditions, and external causes of injury or diseases that healthcare providers encounter. The coding system is designed to ensure that healthcare data is standardized and can be universally understood, facilitating reporting, billing, and epidemiological studies. In contrast, the other numerical options do not accurately represent the current and recognized figures for the total amount of codes present in the ICD-10-CM, thereby confirming the validity of 120,000 as the most factually accurate choice.

5. Which term best describes the act of lowering the foot?

- A. Plantar flexion**
- B. Dorsiflexion
- C. Abduction
- D. Adduction

The term that best describes the act of lowering the foot is plantar flexion. This movement occurs when the foot moves in a downward direction, pointing the toes away from the shin. It is a key motion involved in activities such as walking, running, and standing on tiptoes. In contrast, dorsiflexion refers to the movement of raising the foot upwards towards the shin, which is the opposite of plantar flexion. Abduction and adduction involve movements related to limbs moving away from or towards the midline of the body, respectively, and are not directly related to foot position in the context of lowering the foot. Thus, understanding these terms is essential in fields such as anatomy and physical therapy, where precise descriptions of movement are necessary.

6. Which term refers to a small collection of clear fluid commonly seen in blisters?

- A. Wheal
- B. Macule
- C. Vesicle**
- D. Fissure

The term that refers to a small collection of clear fluid commonly seen in blisters is "vesicle." Vesicles are typically small, raised lesions that can contain serous fluid, and they can be found on the skin or mucous membranes. They are often caused by conditions such as friction, infections, or allergic reactions, leading to the formation of blisters filled with clear fluid beneath the epidermis. In contrast, a wheal is a raised, itchy area of skin that can result from an allergic reaction, a macule is a flat, discolored spot on the skin that does not rise above the surrounding skin, and a fissure is a deep slit or crack in the skin. Understanding these definitions helps in recognizing how vesicles differ in characteristics and causes from other skin lesions.

7. What term describes a structure located above another structure?

- A. Inferior
- B. Superior**
- C. Medial
- D. Lateral

The term that describes a structure located above another structure is "superior." In anatomical terminology, "superior" refers to a position that is higher or above another part of the body. This is commonly used to describe the location of organs or tissues in relation to one another. For instance, the head is superior to the neck, meaning it is positioned higher in the body. This terminology is essential when discussing anatomy and understanding how different parts of the body interact or relate in terms of their positions. Being familiar with directional terms such as "superior" aids in clearly communicating medical information and in accurately documenting patient care in electronic health records, which is a key component of a Certified Electronic Health Records Specialist's role.

8. What describes internet-based, tethered access to personal health records (PHR)?

- A. Access through a web application with user authentication
- B. Access granted by an organization like insurance or healthcare providers**
- C. Access that ensures complete privacy and security
- D. Access limited to individuals without organizational support

Access to personal health records (PHR) through an internet-based, tethered model often involves a framework in which healthcare organizations, such as providers or insurance companies, manage and facilitate the access to these records for patients. In this context, "tethered" means that the access is closely linked to a specific healthcare entity that provides the PHR platform. It typically requires user authentication to ensure that only authorized individuals can view or manage their health information. This model provides patients with a convenient way to view their medical records, check test results, and manage appointments while ensuring that the information remains linked to the health system that maintains the records. It allows for a more organized approach to personal health management since the data originates from a trusted source, and users have access to their records through the healthcare provider's secure portal. The other options do not fully encapsulate the concept of tethered access effectively. For example, while authentication is essential, simply having a web application with user authentication does not define the relationship between the patient and the healthcare organization that governs access. Furthermore, while privacy and security are important in any PHR system, the tethered nature emphasizes the organization's role rather than guaranteeing complete privacy. Lastly, access limited to individuals without organizational support would not

9. What is the primary function of the integumentary system?

- A. Nutrition absorption
- B. Production of blood cells
- C. Protection**
- D. Movement assistance

The primary function of the integumentary system is protection. This system, which includes the skin, hair, nails, and associated glands, serves as the body's first line of defense against external threats. It protects against physical injuries, harmful pathogens, and environmental factors such as UV radiation and temperature fluctuations. The skin acts as a barrier, preventing the loss of body fluids and protecting internal organs from damage. Additionally, the integumentary system plays a role in sensation, helping the body detect changes in the environment through nerve endings in the skin. While other systems listed, such as the production of blood cells or assistance in movement, are crucial for various bodily functions, they do not pertain to the primary functions of the integumentary system.

10. What does the prefix "pre-" signify?

- A. Excision
- B. Before**
- C. Deficient, below
- D. Process of measurement

The prefix "pre-" signifies "before." It is commonly used in medical terminology and other fields to indicate that something occurs prior to a certain event or condition. For instance, in terms like "preoperative," it indicates a phase that happens before surgery. This understanding of the prefix is important in numerous contexts, including medical records management, where the timing of events can be critical to patient care and treatment planning. The other options reflect different meanings that do not align with the definition of the prefix "pre-." Excision relates to cutting something out, deficient refers to something that is lacking or below a normal level, and the process of measurement does not connect to an indication of time or sequence. Understanding the correct meaning of prefixes is essential in the medical field, as it helps professionals accurately document, comprehend, and communicate about various conditions and procedures.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://certifiedelectronichealthrecordsspecialist.examzify.com>

We wish you the very best on your exam journey. You've got this!

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