ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

GEORGIA

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require, so you can advocate for yourself and your patients.

Last updated October 2025

Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic pregnancies and pregnancies with no cardiac activity is legal.

Providing information about how to obtain a legal abortion in another state is legal.

Abortion is prohibited under Georgia law after cardiac activity is detectable (around 6 weeks LMP) unless:

(1) the patient has a "medical emergency," meaning abortion is necessary to "prevent the death" of the patient or to prevent the "substantial and irreversible physical impairment of a major bodily function,"

(2) the pregnancy is the result of rape or incest, is reported to authorities, and is 22 weeks LMP or less, or

(3) the pregnancy is "medically futile," meaning the fetus has a condition "incompatible with sustaining life after birth."

Litigation of the constitutionality of the ban is ongoing.

Last updated October 2025

ABORTION DEFENSE NETWORK

GEORGIA

Definition of Abortion & Contraception

ABORTION

Georgia law defines abortion to include only certain induced abortions, specifically: "'Abortion' means the act of using, prescribing, or administering any instrument, substance, device, or other means with the purpose to terminate a pregnancy with knowledge that termination will, with reasonable likelihood, cause the death of an unborn child."[1] "Unborn child" is defined as "a member of the species Homo sapiens at any stage of development who is carried in the womb."[2]

The following are explicitly *excluded* from Georgia law's definition of abortion: (1) removing "an ectopic pregnancy,"; and (2) removing "a dead unborn child caused by spontaneous abortion."[3] While undefined, it is generally understood that in the context of Georgia's definition of abortion, "dead" means that there is no cardiac activity present in the embryo or fetus. This means that treatment for ectopic pregnancy (including use of methotrexate and surgical removal) and treatment for miscarriage where there is no cardiac activity (including medications, D&C, D&E, labor induction) are *not* abortions under Georgia law and thus are not prohibited by its abortion ban.

Miscarriage care is legal, so long as there is no cardiac activity. With respect to self-managed abortion, it is legal for providers to give medical care during or after a self-managed abortion provided there is no cardiac activity, or if the patient is experiencing a complication that would qualify as a medical emergency, the pregnancy is the result of rape or incest, or the pregnancy is medically futile (see below). There is not an explicit crime of self-managed abortion in Georgia law, and no civil law explicitly prohibiting a person from self-managing an abortion.

CONTRACEPTION

Contraception is not illegal in any state in the country. Georgia's legal definition of abortion explicitly states that it "shall not include the prescription or use of contraceptives."[4]

6-Week Abortion Ban

Georgia law only allows abortions before cardiac activity is detectable. Because cardiac activity is detectable starting around 6 weeks LMP, this is sometimes referred to as a 6-week abortion ban. Before performing an abortion, a physician must make "a determination of the presence of a detectable human heartbeat . . . of an unborn child."[5] Failure to determine the presence of cardiac activity subjects a physician to criminal and civil penalties as well as loss of medical license.[6] "Detectable human heartbeat" is defined as "embryonic or fetal cardiac activity or the steady and repetitive rhythmic contraction of the heart within the gestational sac."[7]

With certain exceptions (discussed below), a physician[8] cannot perform an abortion "if an unborn child has been determined . . . to have a detectable human heartbeat."[9] A violation of the ban is punishable by imprisonment for between 1 and 10 years.[10]

In the same piece of legislation as the 6-week ban, the Georgia legislature also redefined the term "natural person" to "mean[ ] any human being including an unborn child" "at any stage of development who is carried in the womb."[11] The State has repeatedly represented in (non-binding) court filings that this definition does not have the effect of prohibiting lawful abortions that take place *before* embryonic/fetal cardiac activity.

A lawsuit challenging the constitutionality of the 6-week ban is ongoing in state court, but the law is currently in effect while litigation continues.

Exceptions to 6-Week Abortion Ban

There are three exceptions to Georgia's 6-week abortion ban. In litigation challenging the constitutionality of the 6-week ban, attorneys from the State have made representations about the scope of these exceptions (discussed below) that, while non-binding, may provide some guidance to clinicians.

Medical Emergency: Georgia law allows abortions after fetal cardiac activity is detectable in cases where a physician determines in their "reasonable medical judgment" that there is a "medical emergency." It defines "medical emergency" as "a condition in which an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[12] The only health condition that is explicitly excluded from the exception is a risk to the patient's life or health that arises from a mental or emotional condition or from self-harm (e.g. suicide).[13] While the State has not provided any binding clarification of the scope of the emergency exception, it has represented in litigation over the 6-week ban that physicians can use their reasonable medical judgment to provide abortions to patients where there is a serious threat to patient health, even if not yet immediate. The State has also stated in litigation that an abortion can be performed under the exceptions, even when embryonic/fetal cardiac activity is ongoing, in cases of "inevitable miscarriage," and specifically referred conditions like preeclampsia, placental abruptions, and preterm premature rupture of membranes ("PPROM").[14]

Rape or Incest: Georgia law allows abortion in cases of "rape or incest," provided that the gestational age of the pregnancy is 22 weeks LMP or less and "an official police report has been filed alleging the offense of rape or incest."[15]

"Medically Futile" Pregnancies: Georgia law allows abortions after fetal cardiac activity is detectable in cases where a physician determines in their "reasonable medical judgment" that "the pregnancy is medically futile."[16] Georgia law defines "medically futile" to mean that "in reasonable medical judgment, an unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth."[17] While the State has not provided any binding clarification of the scope of the medically futile exception, it has represented in litigation over the 6-week ban that physicians can use their reasonable medical judgment to determine when a pregnancy is unlikely to result in a child with sustained life after birth, citing trisomy 13 as one example of a medically futile condition.[18]

For the purposes of each of these exceptions, Georgia law defines "reasonable medical judgment" as "medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved."[19]

If a physician has determined that either the medical emergency exception or the medically futile exception applies, the physician does not need to comply with Georgia's requirement to determine if the pregnancy has a detectable human heartbeat.[20] Several of Georgia's other abortion restrictions also do not apply in medical emergencies. Specifically: the physician does not need to comply with Georgia's mandatory disclosure requirements and 24-hour waiting period;[21] and for young people under 18, a physician does not need to notify their parent if the young person's condition requires "an immediate abortion."[22] However, there is some variation in how "medical emergency" is defined across Georgia's abortion restrictions For instance, unlike the definition used for purposes of Georgia's 6-week ban, the medical emergency exception to Georgia's law governing informed consent for abortion says

that the patient's condition must necessitate an "immediate" abortion, but that the health risk can be "substantial *or* irreversible" (emphasis added), instead of both.[23]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires the provision of abortion care when necessary to stabilize an emergency medical condition. Specifically, EMTALA requires hospitals with emergency departments that participate in Medicare (i.e., most hospitals) to perform a medical screening exam for any individual who comes to the emergency department and requests evaluation or treatment, in order to determine whether the individual has an emergency medical condition.[24] EMTALA defines "emergency medical condition" to include "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[25] Additionally, "with respect to a pregnant woman who is having contractions," an "emergency medical condition" is further defined to include when "there is inadequate time to effect a safe transfer to another hospital before delivery" or when "transfer may pose a threat to the health or safety of the woman or the unborn child."[26]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[27] including people in labor or with emergency pregnancy complications,[28] unless the individual refuses to consent to such treatment.[29] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[30] A person experiencing an emergency medical condition can be transferred to a different hospital only once they are stable or if certain other conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[31] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health."[32]

Where abortion, including the premature delivery of a non-viable fetus, is the medical treatment necessary to, within a reasonable probability, ensure no material deterioration of an individual's condition, EMTALA requires a covered hospital provide such care or, if the aforementioned criteria are met, an appropriate transfer. The U.S. Department of Health and Human Services ("HHS") has reaffirmed these requirements numerous times.[33]

Most recently, on June 13, 2025, HHS Secretary Robert F. Kennedy distributed a letter to health care providers reiterating that, notwithstanding the recent rescission of earlier guidance on the subject, "EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care."[34] The letter specifically states that EMTALA "applies equally to expectant mothers facing obstetric emergencies, including ectopic pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions."[35] And, during a June 24, 2025, subcommittee hearing in the U.S. House of Representatives, Secretary Kennedy was asked explicitly about whether he agreed that in some circumstances abortion is the necessary stabilizing care that EMTALA requires hospitals to provide, to which he responded, "Yes, and that is what President Trump believes."[36] Further, as recently as May 2025, HHS announced that it had cited at least

one hospital in Texas for violating EMTALA by failing to properly screen a patient with an ectopic pregnancy, an emergency medical condition that threatened the patient's life and future fertility.[37]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, state officials in Idaho and Texas have attempted to restrict hospitals from complying with their federal legal obligations, resulting in litigation, but with only varying degrees of success.

In January 2025, Idaho's largest hospital system, St. Luke's Health System, filed a lawsuit seeking to prevent the state of Idaho from enforcing its abortion ban, which creates criminal penalties for the provision of certain emergency abortions required under EMTALA.[38] St. Luke's was successful in obtaining a preliminary injunction that prevents the state of Idaho from enforcing its abortion ban "against St. Luke's or any of its medical providers as applied to medical care required by [EMTALA]."[39] Litigation in that case is ongoing. St. Luke's case is related to one brought in 2022 by the Biden Administration, *United States v. Idaho*, in which the federal government sued Idaho challenging its abortion ban to the extent that it conflicted with EMTALA.[40] That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.[41] Following the change of presidential administrations, the United States dismissed that case entirely. [42]

And, in October 2024, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of EMTALA in certain circumstances in Texas and as to other organizational plaintiffs in that case.[43] As a result, the Fifth Circuit's decision is final.[44] [45]

Other Federal Laws & Professional Guidelines

In addition to EMTALA, hospitals and/or medical providers are required to abide by the following:

Conditions of Participation in Medicare and Medicaid (COP): The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: the right to be informed of their health status, be involved in care planning and treatment, and participate in the development of their plan of care.[46]

Protection Against Discrimination in Employment: The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against health care providers who participate or are willing to participate in abortion care or sterilization procedures.[47]

Medical Malpractice: While this document does not detail state-specific medical malpractice law, medical providers should be aware that they risk liability under state medical malpractice law for failing to provide pregnant patients with the standard of care.[48]

Regulatory Sanctions: While this document does not detail state-specific regulations of healthcare facilities or licensees, medical providers should be aware that the Georgia Department of Public Health and Georgia Department of Community Health issued a joint notice stating that "physicians in Georgia are expected to follow standards of care in providing treatment for pregnant women in emergent situations" and warning that "[t]he failure to act timely in critical situations may result in regulatory sanctions from the Healthcare Facility Regulation Division of the Department of Community Health or other State boards and agencies."[49]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[50] The federal law known as the Coats-Snowe Amendment both protects medical professionals in learning to provide abortion, and limits the government's ability to penalize programs or institutions that fail to comply with ACGME requirements.[51]

Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it explicitly require reporting to law enforcement patients who receive abortions out of state or self-manage their own abortion.[52] The only abortion-specific documentation and reporting requirements are:

Documentation: Georgia law requires that if a "detectable human heartbeat" exists, the physician must report "the probable gestational age, and the method and basis of the determination."[53] If a "detectable human heartbeat" exists and an abortion is performed under an exception to the 6-week ban, the physician must report "the basis of the determination that the pregnant woman had a medically futile pregnancy, that a medical emergency existed, or that the pregnancy was a result of rape or incest; and . . . "[t]he method used for the abortion."[54] Georgia law also requires that when a physician performs an abortion under the "medical emergency" exception for a young person under 18 and there is insufficient time to notify a parent, the physician must "certify in writing the medical indications on which this judgment was based when filing such reports as are required by law."[55]

Some hospitals may impose additional documentation requirements for abortions performed as medical emergencies, including attestations by multiple physicians and/or approvals by an ethical review board. While intended to insulate the hospital from liability, these are not legal requirements.

Abortion Reporting: Georgia law requires that the physician report induced abortions[56] including any emergency complications from the procedures to the state through the Induced Termination of Pregnancy (ITOP) reporting system.[57]

Fetal Death Reporting: Georgia law requires reporting "spontaneous fetal deaths," including stillborn pregnancies and medical procedures to remove pregnancy tissue following miscarriage at any gestational age, to the local registrar within 72 hours after the procedure or delivery.[58] The ITOP reporting system has a separate fetal death module where these cases should be reported.

Other Mandatory Reporting: All other general mandatory reporting to the Department of Family and Protective Services, local law enforcement, etc., also applies for abortion patients.[59] This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse.[60]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions. Hospital and other healthcare systems often use their EMR's default settings that widely share patient records.[61] Though these settings are often helpful for continuity of care, they may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[62, 63]

EMRs have settings that can limit sharing of certain records and/or allow patients to choose how and when their records are shared, but because these are not the default settings, healthcare systems often must take steps to implement them.[64] For example,

one EMR, Epic, has a filter that each Epic healthcare system can choose to turn on that exclusively blocks abortion care information from patients' externally-shared medical records, while allowing each patient's other medical records to be transmitted in full, in line with their authorization. We encourage you to discuss with your institution's general counsel and/or compliance or technology officers counsel alternative settings such as this that can protect abortion patient information while also complying with any other legal requirements.[65]

Counseling & Referral

Speech about abortion is legal in Georgia. Medical professionals in Georgia can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal.

Medication Abortion

All of the requirements discussed in this document apply to both procedural and medication abortion. While some states have additional laws that apply specifically to medication abortion, Georgia does not have any of these laws currently in effect.

Disposition of Fetal Tissue Remains

While Georgia law has a longstanding requirement regarding the disposition of embryonic and fetal tissue remains from both abortion and miscarriage procedures, it was never challenged in court because it has not significantly impacted medical practice. Specifically, medical facilities are required to dispose of such tissue by "cremation, interment, or other manner approved of by the commissioner of public health."[66] This requirement does not apply to vitro fertilization, medication abortion, or any process where the patient passes the pregnancy tissue outside of a medical facility, nor does it put any requirements on patients.

Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

ACLU

CENTER for REPRODUCTIVE RIGHTS

THE LAWYERING PROJECT

NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] Ga. Code § 16-12-141(a)(1); Ga. Code § 15-11-681; Ga. Code § 31-9A-2(1).
[2] Ga. Code § 1-2-1(e)(2); Ga. Code § 31-9A-2(7).
[3] Ga. Code § 16-12-141(a)(1); *see also* Ga. Code § 15-11-681; Ga. Code § 31-9A-2(1).
[4] Ga. Code § 15-11-681; Ga. Code § 31-9A-2(1).
[5] Ga. Code § 31-9B-2(a).
[6] Ga. Code § 31-9B-2(b).
[7] Ga. Code § 16-12-141(a)(2); Ga. Code § 1-2-1(e)(2).
[8] Georgia law limits the performance of abortions to physicians, which are defined as "a person licensed to practice medicine." Ga. Code § 16-12-141(e)(2); Ga. Code § 31-9A-2(3).
[9] Ga. Code § 16-12-141(b).
[10] Ga. Code § 16-12-140(b).
[11] Ga. Code § 1-2-1.
[12] Ga. Code § 16-12-141(a)(3); *see also* Ga. Code § 31-9A-2(2); Ga. Code § 15-11-686.
[13] Ga. Code § 16-12-141(a)(3): "No such greater risk shall be deemed to exist if it is based on a diagnosis or claim of a mental or emotional condition of the pregnant woman or that the pregnant woman will purposefully engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function."
[14] State's Post-Trial Br. at 22, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796 (Ga. Super. Ct. Nov. 4, 2022); *see also* Transcript of Oral Argument at 28–29, 70, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796, 2022 WL 16960560 (Ga. Super. Ct. Oct. 24, 2022).
[15] Ga. Code § 16-12-141(b)(2); Ga. Code § 31-9B-1(5) (explaining that Georgia law measures gestational age as post-fertilization, which is two weeks less than LMP).
[16] Ga. Code § 16-12-141(b)(3).
[17] Ga. Code § 16-12-141(a)(4).
[18] Trial Transcript Day 2 at 377, 405–07, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796, 2022 WL 16960560 (Ga. Super. Ct. Oct. 25, 2022).
[19] Ga. Code § 31-9B-1(6).
[20] Ga. Code § 31-9B-2(a).
[21] Ga. Code 31-9A-3.
[22] Ga. Code § 15-11-686.
[23] Ga. Code § 31-9A-2(2): "'Medical emergency' means any condition which, in reasonable medical judgment, so complicates the medical condition of a pregnant female as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial or irreversible impairment of a major bodily function of the pregnant woman or death of the unborn child. No such condition shall be deemed to exist if it is based on a diagnosis or claim of a mental or emotional condition of the pregnant woman or that the pregnant woman will purposefully engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function."
[24] EMTALA, 42 U.S.C. § 1395dd(a).
[25] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[26] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[27] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[28] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[29] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[30] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[31] EMTALA, 42 U.S.C. § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[32] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[33] For example, in 2022, the Biden Administration issued guidance reiterating past administrative statements that the treatment required by EMTALA includes abortion care when such care is necessary to stabilize a pregnant person's emergency medical condition. Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients*

who are Pregnant or are Experiencing Pregnancy Loss (updated July 2022) ("2022 EMTALA Guidance"). While this guidance has since been rescinded, the requirements of EMTALA as outlined in it and other prior HHS statements have not changed. Indeed, in the Trump Administration's June 3, 2025 statement rescinding the 2022 guidance, the Administration stated that "CMS will continue to enforce EMTALA . . . including for identified emergency medical conditions that place the health of a pregnant woman or unborn child in serious jeopardy." Ctrs. for Medicare & Medicaid Servs., *CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA)* (June 3, 2025); *see also* Letter from Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., to Healthcare Providers (June 13, 2025) ("Kennedy Letter"), available at https://essentialhospitals.org/wp-content/uploads/2025/06/6.13.25-EMTALA-letter-final.pdf.pdf.

[34] Kennedy Letter.

[35] Kennedy Letter.

[36] *Hearing on the Fiscal Year 2026 Dep't of Health and Hum. Servs. Budget Before the H. Comm. on Energy & Com., Subcomm. on Health,* 119th Cong. (2025) (statement of Robert F. Kennedy Jr., Sec'y of Health & Hum. Serv.).

[37] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).

[38] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).

[39] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).

[40] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).

[41] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).

[42] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).

[43] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).

[44] *Texas v. Becerra*, 89 F.4th 529, 546 (5th Cir. 2024) (affirming permanent injunction barring HHS from enforcing the 2022 EMTALA Guidance's "interpretation that Texas abortion laws are preempted by EMTALA" and "it's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against [plaintiff organizations'] members."); *see also* Ctrs. for Medicare & Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act (last modified Dec. 6, 2024).

[45] A separate challenge to the guidance was filed by the Catholic Medical Association in Tennessee, Compl., *Catholic Med. Ass'n v. Dep't of Health & Hum. Servs.*, No 3:25-cv-00048, ECF No. 1 (M.D. Tenn. Jan. 10, 2025), but the plaintiff voluntarily dismissed that action on June 3, 2025.

[46] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[47] Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment, NAT'L WOMEN'S LAW CTR. (Feb. 9, 2023), https://nwlc.org/resource/know-your-rights-existing-laws-may-protect-health-care-professionals-who-provide-or-support-abortion-from-discrimination-in-employment/.

[48] *See* Ga. Code § 51-1-27; Ga. Code § 9-3-70 et seq.

[49] Ga. Dep't of Public Health & Ga. Dep't of Community Heath, *Notice to Health Care Providers Regarding Misinformation About Abortions in Georgia* (Sept. 25, 2024), https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/NOTICES/Provider%20Announcement%20Sept%2025%202024%20final%20240925193207.pdf.

[50] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).

[51] 42 U.S.C. § 238n.

[52] There is no reason to report a self-managed abortion to the police. Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.

[53] Ga. Code § 31-9B-3(a)(1).

[54] Ga. Code § 31-9B-3(a)(2).

[55] Ga. Code § 15-11-686.

[56] Ga. Code § 16-12-141.1(c); Ga. Code § 31-9A-6; Ga. Code. § 31-9B-3.

[57] https://gavers.dph.ga.gov/Welcome.htm The state reporting form includes a section for reporting abortion complications, but state law only explicitly requires reporting of complications that are also medical emergencies. *See* Ga.

Code § 16-12-141(a)(3); Ga. Code. § 31-9B-3.

[58] Ga. Code § 31-10-18. "Spontaneous fetal death" is defined as "the expulsion or extraction of a product of human conception resulting in other than a live birth and which is not an induced termination of pregnancy." Ga. Code § 31-10-1(15).

[59] Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.

[60] Ga. Code § 19-7-5; Ga. Code § 30-5-4.

[61] For example, an EMR may employ a tool that securely shares information among healthcare institutions that use the same EMR (e.g., from one hospital system to another) and allows robust sharing among affiliated healthcare institutions (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same health system).

[62] For example, if a patient travels from a ban state to an access state for abortion care or obtains an abortion in the ban state under an exception, then later obtains any type of healthcare at a different provider that uses the same EMR, the patient's records may be automatically shared with the second provider. If the second provider believes that the care violated the state's abortion ban, they may report it to authorities.

[63] Some states have taken steps to address vulnerabilities in information sharing, specifically for abortion and gender-affirming care. For example, Maryland and California, among other states, have enacted laws that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. *See, e.g.,* H.B. 812, 445th Leg., Reg. Sess. (Md. 2023), A.B. 352, 2023 Leg., Reg. Sess. (Cal. 2023).

While the federal government under the Biden administration created additional HIPAA protections related to the disclosure of reproductive health care records by issuing a HIPAA Reproductive Health Rule, in 2025, a federal district court vacated the rule nationwide and the requirements of the rule are no longer in effect (except for the notice of privacy practices provisions related to substance use disorder treatment records, which go into effect on February 16, 2026). HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32976 (2024) (modifying 45 C.F.R. §§ 160, 164), *Purl v. U.S. Dep't of Health & Hum. Servs.*, No. 2:24-cv-228-Z (N.D. Tex. Jun 18, 2025) (vacating the majority of the rule). All HIPAA protections that were in place prior to this rule remain in place.

[64] Many of these setting options are quite broad, blocking not only a subsequent provider's access to more "sensitive" information, but also to less sensitive information that is critical to continuity of care. For this reason, many patients may not want to limit access to their records.

[65] E.g., healthcare institutions must comply with interoperability rules that penalize certain information blocking (though exceptions are available). *See* 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). *See also* Health Data, Technology, and Interoperability: Protecting Care Access, 89 Fed. Reg. 102512 (Dec. 17, 2024) (adding 45 C.F.R. § 171.206 to except information blocking practices intended to reduce potential exposure to legal action based on lawful reproductive health care provision, subject to certain conditions). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians.

[66] Ga. Code § 16-12-141.1(a)(1).