ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

SOUTH DAKOTA

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 April 2025

Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic pregnancies and miscarriages is legal.

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

Abortion is prohibited under South Dakota law unless there is “appropriate and reasonable medical judgement” that an abortion is necessary to preserve the life of the pregnant person.

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Definition of Abortion & Contraception

ABORTION

The legal definition of abortion in South Dakota is "the intentional termination of the life of a human being in the uterus."[1] South Dakota law asserts that "all abortions, whether surgically or chemically induced, terminate the life of a whole, separate, unique, living human being."[2] The South Dakota Department of Health has stated[3] that "[i]ntent plays a crucial role" in defining abortion, and therefore the treatment for a miscarriage, ectopic pregnancy, or in a situation "where the fetus never forms" are not considered abortions, and physicians should treat these conditions as "they always have" with the most "clinically appropriate procedure."[4]

No law prevents treating a patient who has self-managed an abortion and required subsequent medical care after the abortion.

CONTRACEPTION

Contraception is not illegal in any state in the country. South Dakota does not explicitly define contraception in its statutory code. There are also no restrictions on what types of contraceptives are available, including for emergency contraception.

Abortion Bans

Total Ban: South Dakota bans abortion "unless there is appropriate and reasonable medical judgment that performance of an abortion is necessary to preserve the life of the pregnant [person]."[5] Violation of the law is a Class 6 felony, and violators are subject to two years imprisonment, a $4,000 fine, or both.[6]

Other Bans & Restrictions: South Dakota has other bans and restrictions on abortion, some of which have emergency exceptions. South Dakota prohibits dilation and extraction ("D&X") procedures, with civil penalties for violation of this provision.[7] Abortions sought due to a fetal Down syndrome diagnosis or suspicion of potential diagnosis are also prohibited, with potential civil penalties for violating this provision.[8]

South Dakota also has a pre-abortion disclosure requirement;[9] a mandatory ultrasound requirement;[10] and a mandatory waiting period of 72-hours between the initial consultation and the procedure or dispensing of medication abortion, all of which have emergency exceptions.[11] During the initial consultation, the physician must provide the patient with a list of registered crisis pregnancy centers and instruct the patient to have a consultation with one of the centers.[12] The physician must have a written statement from the patient that the patient obtained a consultation from a specified crisis pregnancy center prior to consenting to the abortion procedure.[13]

There is an affirmative duty on the physician to assess that the patient is not being coerced into seeking an abortion, though this is not required in certain medical emergencies.[14] As part of assessing that the patient is not being coerced into seeking an abortion, physicians "shall obtain from the pregnant mother the age or approximate age of the father of the unborn child, and the physician shall consider whether any disparity in age between the mother and father is a factor when determining whether the pregnant mother has been subjected to pressure, undue influence, or coercion."[15]

South Dakota requires that parents or guardians receive written notice of a pending abortion procedure at least 48 hours prior to the abortion being performed, or obtain permission from a judge to waive this requirement.[16] Notice is not required if there is a medical emergency and insufficient time to provide notice; however, notice must be sent 24 hours after the emergency abortion.[17]

Performing an abortion sought for reasons based on the sex of the fetus is prohibited and a Class C felony with no emergency exceptions and potential life imprisonment, a harsher punishment than the state's total abortion ban.[18] South Dakota has a physician-only requirement—meaning a only a physician can perform an abortion—and there is no emergency exception for this requirement.[19]

Abortion Ban Exceptions

South Dakota's abortion ban has an exception to save the life of the pregnant person.[20] The South Dakota Department of Health stated that "South Dakota law does not require a woman be critically ill or actively dying for a needed medical intervention to end the pregnancy."[21] The Department provided a "non-exhaustive list of conditions that could necessitate ending a pregnancy pre-viability, including the following:

- The presence of active hemorrhage into the peritoneal cavity, pelvic cavity, pelvic organs, or through the cervical canal associated with a maternal hemoglobin of less than 9.0 grams per deciliter, hematocrit less than 27.0, or profuse bleeding;
- Intrauterine infection as defined by 2 or more signs including: maternal fever greater than 100.4 degrees, uterine tenderness, persistent maternal heart rate greater than 100, persistent fetal heart rate greater than 160, or foul-smelling discharge through the cervical ostium;
- Premature rupture of the membranes prior to 24 weeks gestational age;
- Severe hyperemesis gravidarum as evidenced by 3 or more hospital stays for dehydration and hypokalemia (that is, blood potassium levels of less than 3 milliequivalents per liter) that is unresolved by multiple medication therapy;
- Cardiovascular collapse associated with obstetric conditions (such as amniotic fluid embolus) or non-obstetric conditions;
- Preeclampsia with severe features, including Hemolysis, Elevated Liver enzyme levels, and Low Platlet levels (HELLP) syndrome or mirror syndrome, occurring prior to 24 weeks gestational age;
- Acute Fatty Liver of Pregnancy;
- Partial molar pregnancy;
- Hemolytic Uremic Syndrome or Thrombotic Thrombocytopenic Purpura;
- Chronic or acute kidney disease with serum creatinine level of 1.4 or greater;
- Prior or planned solid organ transplant;
- Current maternal malignancy;
- Poorly controlled autoimmune disease, such as catastrophic antiphospholipid syndrome, scleroderma renal crisis, or severe lupus nephritis; or
- Substantial cardiovascular disease as defined by WHO III and IV."[22]

However, the Department noted that physicians still must use their medical judgment, as an abortion is not always permitted in these circumstances if the life of the pregnant person is not endangered.[23] The Department stated that physicians should "thoroughly document" the clinical assessment that led to their conclusion that an abortion is necessary to save the life of the pregnant patient.[24]

Other Legal Requirements: The physician that conducted the initial consultation may obtain informed consent from the patient and perform the abortion procedure or medication abortion, "unless serious unforeseen circumstances prevent that physician from taking the consent and performing the abortion."[25] Physicians are required to use a specific informed consent form that details the necessary disclosures.[26] However, the informed consent requirements discussed above do not apply

in situations where "consent is impossible due to a medical emergency," or where delaying the procedure to obtain informed consent from the patient or their "next of kin" is impossible."[27] The term "medical emergency" is defined as "any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function."[28] Hospitals may refuse to admit patients "for the purpose of terminating a pregnancy."[29]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires emergency abortion care in some cases. EMTALA requires Medicare-participating hospitals with emergency departments (which includes most hospitals), to perform a medical screening to determine whether an emergency medical condition exists for any individual who comes to the emergency department and requests an examination or treatment.[30] Stabilizing medical treatment must be provided to individuals experiencing an emergency medical condition,[31] including people in labor or with emergency pregnancy complications.[32] 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."[33] A person experiencing an emergency medical condition can only be transferred to a different hospital once they are stable or if certain conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[34] 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."[35] 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."[36] The stabilizing treatment required by EMTALA can include abortion care in certain circumstances.

The U.S. Department of Health and Human Services ("HHS") reaffirmed these requirements in guidance issued after *Roe v. Wade* was overturned. That guidance emphasizes that stabilizing treatment required by EMTALA could include abortion care if the examining physician or other qualified medical personnel determines that such treatment is required to stabilize a patient experiencing an emergency medical condition, including a condition that is "likely or certain to become emergent without stabilizing treatment."[37] The guidance made clear those conditions might include, but are not limited to: "ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."[38] The guidance reiterates that if EMTALA requires the provision of abortion care, then EMTALA expressly preempts any state law prohibiting or restricting access to abortion.[39] Indeed, since *Dobbs*, HHS has cited hospitals in Kansas, Missouri, and Florida for violating EMTALA by failing to provide abortion care to a patient with PPROM or other life-threatening pregnancy condition.[40]

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.

In 2022, in *United States v. Idaho*, the federal government sued Idaho and obtained a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA.[41] After temporarily staying that injunction,[42] the U.S. Supreme Court lifted the stay and restored the preliminary injunction in June 2024.[43]

Following the change of presidential administrations, the United States dismissed its case, effectively eliminating the injunction entered in that case. [44] By that time, however, a hospital system had filed a separate lawsuit and obtained a temporary restraining order, and subsequently a preliminary injunction, effectively maintaining the status quo, meaning that Idaho still cannot enforce its abortion ban in circumstances where EMTALA would require abortion care.[45]

Meanwhile in Texas, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of HHS' 2022 EMTALA guidance in Texas and as to other plaintiffs in that case. As a result, the Fifth Circuit's decision affirming the permanent injunction against the 2022 EMTALA guidance is final. This means HHS may not enforce the 2022 guidance in Texas or against any member of the American Association of Pro-Life OBGYNs (AAPLOG) or Christian Medical & Dental Associations (CMDA).[46, 47]

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.[48]
- **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.[49]
- **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.[50]
- **Resident Training:** The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[51] 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.[52]

Documentation and 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.[53] The South Dakota Department of Health recommends clearly documenting in the patient's medical records the medical reasoning behind providing an abortion

under the state's exception to "preserve the life of the pregnant [person]."[54] Hospitals may have specific policies on how to approach documenting emergency abortion procedures. The only abortion-specific reporting requirements are:

Abortion Reporting: Abortion facilities and physicians are required to report specific data to the South Dakota Department of Health, including:

(1) The number of abortions performed;

(2) The method of abortion used in each abortion performed;

(3) Complete pathology reports including the period of gestation of fetuses, the presence of abnormality, and the measurements of fetuses, if the facility where the abortion is performed is equipped to complete the reports;

(4) The number of maternal deaths due directly or indirectly to abortions;

(5) Reports of all follow-up, including short-term and long-term complications due to abortion in the female who received an abortion;

(6) The number of infants who survived an attempted abortion;

(7) Medical action taken to preserve the life of an aborted child born alive;

(8) The outcome for an aborted child born alive, including the child's survival, death, and location of death, if known; and

(9) Any other information required by the department, as authorized by this section.[55]

The above information, along with additional data, is collected by the South Dakota Department of Health on an annual basis, due January 15th of each calendar year.[56]

Minors: Physicians must report the number of notices sent to the parents of minors seeking an abortion, and the number of those minors that then went on to obtain abortion care.[57] The report must also include the number of abortions performed on minors, and designate the number of patients whose parents received notice and those who fell into other exceptions to the notice requirement (such as the minor being emancipated, or the minor obtaining a judicial waiver).[58]

Informed Consent Reporting: Physicians must report to the South Dakota Department of Health the number of patients the physician provided the mandatory informed consent information to.[59] Physicians must also report the number of patients the physician provided information about medical assistance, child support, other potential programs, and the written state-provided disclosures.[60] Physicians must report the number of patients who requested a copy of written disclosures, and of those, how many then obtained abortion care.[61] The physician must report the number of patients who declined or opted to view the mandatory sonogram, as well as those that went onto receive abortion care after viewing the sonogram.[62] The physician must report abortions that were performed without the required disclosures due to a medical emergency that necessitated abortion care to save the life of the patient.[63] In the initial consultation, the physician must also evaluate whether the patient has any of the following alleged "risk factors" that coincide with "adverse psychological outcomes following an abortion."[64] The physician must indicate in the patient's medical records which factors are or are not present, and note in the patient's medical record that the physician discussed any present alleged risk factors with the patient.[65]

Fetal Death Reporting: South Dakota law requires "[a] fetal death report for the death of each fetus which has attained a gestational age of not less than twenty completed weeks and is not an abortion."[66] The report must be filed by the "physician or other person in attendance at or after the delivery . . . to the Department of Health within seven days of

delivery."[67] South Dakota defines the term "stillbirth" to be "any intrauterine fetal death occurring in this state after a gestational age of not less than twenty completed weeks."[68] In instances where a stillbirth occurs, according to the South Dakota definition, a physician must also "advise the parent or parents of a stillborn child" that they may request a birth certificate, and the means to contact the Department of Health to do so.[69] There are no fetal death reporting requirements prior to twenty weeks gestation.

Other Mandatory Reporting: All other general mandatory reporting also applies for abortion patients.[70] This includes reporting known or suspected child abuse or neglect.[71] Child abuse and neglect include sexual abuse, molestation, or exploitation "by the child's parent, guardian, custodian, or any other person responsible for the child's care."[72]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[73] While EMRs have settings that allow patients to choose how and when their records are shared, hospital systems often instead use their EMR's default settings that widely share patient records. Though often done for continuity of care purposes, these settings 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.[74]

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.[75] The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct an investigation into or impose liability on any person solely for seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[76] A provider who receives a request to disclose PHI potentially related to reproductive care must obtain an attestation from the requestor that the request is not for a prohibited purpose.[77] The attestation is required when the request is for: law enforcement purposes, disclosures to coroners and medical examiners, judicial and administrative proceedings, and health oversight activities.[78] If the abortion care – self-managed or otherwise – was provided by someone else, the rule allows a provider to assume it was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[79] The rule only applies to healthcare providers who are subject to HIPAA.[80] Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.[81]

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.[82] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions that may be available with your institution's compliance officers, counsel, and/or technology officers.[83]

Counseling and Referral

Speech about abortion is legal in South Dakota. Medical professionals, and those in other profession where "the abortion question may appear as part of their workday routine," can refer patients to medical providers in states where abortion is legal, and assist in arranging for the patient's abortion care in another state.[84]

Medication Abortion

South Dakota limits the use of medication abortion to nine weeks gestation.[85] The physician that provided the informed consent materials and mandatory disclosures must administer the initial Mifepristone dose, "unless serious unforeseen circumstances prevent that physician from taking the consent and performing the abortion."[86] The patient

must take the first dose of mifepristone at the medical facility, wait for a suitable observation period, and then may return home.[87] The patient then must return to the facility 24-72 hours for Misoprostol, which must be dispensed by the same physician.[88] The patient is required to schedule a follow-up appointment 14 days after taking the medication.[89] Pharmacists may refuse to dispense medication abortion and contraceptives in South Dakota.[90]

Disposition of Fetal Tissue Remains

Unless the abortion was to prevent the death of the pregnant person, "any tissue, organ, or body part . . . may not be used in animal or human research or for animal or human transplantation."[91]

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), If/When/How: Lawyering for Reproductive Justice, National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

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RAD RESOURCES FOR ABORTION DELIVERY

References

[1] S.D. CODIFIED LAWS § 34-23A-1.

[2] *Id.* § 34-23A-1.2.

[3] Under South Dakota Codified Laws § 34-23A-94, the Department of health was required create an informational video that describes "acts that do and do not constitute an abortion," and "common medical conditions that threaten the life or health of a pregnant woman." South Dakota also required this video to list "the generally accepted standards of care applicable to the treatment of a pregnant woman experience life-threatening or health-threatening medical conditions" as well as "criteria" a physician "might use in determining the best course of treatment for a pregnant woman experiencing life-threatening conditions." *Id.*

[4] South Dakota Department of Health, *Medical Education & Guidance | South Dakota's Law & Medical Conditions*, YouTube (Sept. 4, 2024), at 0:56, https://www.youtube.com/watch?v=vrYxPkSzTTw&t=96s.

[5] S.D. CODIFIED LAWS § 22-17-5.1.

[6] *Id.* § 22-17-5.1; § 22-6-1.
[7] *Id.* §§ 34-23A-27; 34-23A-29; 34-23A-30; 34-23A-31; 34-23A-32; 34-23A-33 (there is an exception to prohibition on the D&X procedure where the procedure is "necessary to save the life of the mother because her life is endangered by a physical disorder, illness, or injury, including a life-endangering condition caused by or arising from the pregnancy itself, if no other medical procedure would suffice." *Id.* § 34-23A-28).
[8] *Id.* §§ 34-23A-89; 34-23A-90; 34-23A-91; 34-23A-93. There is an exception to this rule for "any abortion that is necessary to save the life of the pregnant woman because her life is endangered by a physical disorder, illness, or injury, including a life-endangering condition caused by or arising from the pregnancy itself, if no other medical procedure would suffice for that purpose." *Id.* § 34-23A-92.
[9] *Id.* §§ 34-23A-10.1; 34-23A-22 (there is an exception if making the disclosures to obtain informed consent from either the patient or a next of kin would be "impossible due to a medical emergency." The determination that the medical emergency made it impossible to make these disclosures must be "documented in the medical records of the patient.").
[10] *Id.* §§ 34-23A-52; 34-23A-52.1 (the ultrasound is not required in the case of a medical emergency, and the physician must "certify the specific medical conditions that constitute the emergency" in the patients medical records).
[11] *Id.* §§ 34-23A-10.1; 34-23A-56; 34-23A-1(5) (the waiting period is not required when there is a "medical emergency," defined as "any condition which, on the basis of the physician's good faith clinic judgment, so complicated the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.).
[12] *Id.* §§ 34-23A-56(3)(b); 34-23A-47 (the requirements that the patient consult a crisis pregnancy center is not required in the case of a "medical emergency," with the same definition as above).
[13] § 34-23A-56(3)(b);(note that the portions of § 35-23A-56 requiring a consultation from a crisis pregnancy center were enjoined temporarily, until the injunction was lifted in 2022. *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Noem*, No. 21-2913, 2022 WL 18861791, at *1 (8th Cir. Oct. 6, 2022)).
[14] *Id.* § 34-23A-56.
[15] *Id.* (note that there is an exception to this requirement for "medical emergencies," defined in § 34-23A-1(5) as "any condition which, on the basis of the physician's good faith clinic judgment, so complicated the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.")
[16] *Id.* § 34-23A-7.
[17] *Id.* § 34-23A-7(1).
[18] *Id.* §§ 34-23A-63; 34-23A-64.
[19] *Id.* § 36-9A-17.2.
[20] S.D. CODIFIED LAWS § 22-17-5.1.
[21] South Dakota Department of Health, *Medical Education & Guidance | South Dakota's Law & Medical Conditions*, YouTube (Sept. 4, 2024), at 1:37, https://www.youtube.com/watch?v=vrYxPkSzTTw&t=96s (South Dakota law 34-23A-94 required the Department of Health to create this video to "describe . . . [t]he state's abortion law and acts that do and do not constitute an abortion." The video is not official guidance that can be unequivocally relied upon).
[22] *Id.* at 2:20.
[23] *Id.* at 4:21.
[24] *Id.* at 4:36.
[25] *Id.* § 34-23A-57.

[26] S.D. ADMIN. R. 44:67:04.
[27] S.D. CODIFIED LAWS § 34-23A-10.1.
[28] *Id.* § 34-23A-1.
[29] *Id.* § 34-23A-14 (note that Medicare-participating hospitals must follow EMTALA, as it is a federal law that takes precedence over state law in this instance).
[30] EMTALA, 42 U.S.C. § 1395dd(a).
[31] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[32] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[33] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[34] 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).
[35] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[36] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[37] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022).
[38] *Id.*
[39] *Id.*; *see also* EMTALA, 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").
[40] Ctrs. for Medicare & Medicaid Servs., *Freeman Health System—Freeman West, Statement of Deficiencies and Plan of Correction* (April 10, 2023); Ctrs. for Medicare & Medicaid Servs., *University of Kansas Hospital, Statement of Deficiencies and Plan of Correction* (April 10, 2023); Caroline Kitchener & Dan Diamond, *She Filed A Complaint After Being Denied An Abortion. The Government Shut Her Down*, WASH. POST (Jan. 19, 2024), https://www.washingtonpost.com/politics/2024/01/19/oklahoma-abortion-emtala/ ("Biden officials also confirmed one additional case that the administration had determined violated EMTALA involving a woman who presented at two hospitals in Florida with a life-threatening pregnancy condition in December 2022."); Press Release, U.S. Dep't of Health and Human Servs., *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement* (May 1, 2023).
[41] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[42] *Idaho v. United States*, 144 S. Ct. 541 (Mem) (2024).
[43] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[44] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[45] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 33 (D. Idaho Mar. 4, 2025); *id.* ECF No. 49 (D. Idaho March 20, 2025).
[46] 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).
[47] 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 federal government has not yet responded.
[48] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[49] 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).
[50] Miss. Code Ann. § 15-1-36.
[51] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (Sept. 17, 2022),

https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022_tcc.pdf.

[52] 42 U.S.C. § 238n.

[53] 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.

[54] S.D. CODIFIED LAWS § 22-17-5.1.

[55] *Id.* § 34-23A-19.

[56] *Id.* §§ 34-23A-34; 34-23A-35.

[57] *Id.* § 34-23A-39; *see also* § 34-23A-7 (requiring notice to parents or guardians 48 hours prior to a minor obtaining abortion care, with specific exceptions for emergencies and for minors who receive a judicial bypass).

[58] *Id.* § 34-23A-39.

[59] *Id.* § 34-23A-37(1).

[60] *Id.* § 34-23A-37(2).

[61] *Id.* § 34-23A-37(3).

[62] *Id.* § 34-23A-37(4).

[63] *Id.* § 34-23A-37(5).

[64] *Id.* § 34-23A-46(4).

[65] *Id.* § 34-23A-56.

[66] *Id.* § 34-25-32.1.

[67] *Id.* § 34-25-32.2.

[68] *Id.* § 34-25.32.8.

[69] *Id.* § 34-25-32.9.

[70] 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.

[71] S.D. CODIFIED LAWS § 26-8A-3.

[72] *Id.* § 26-8A-2.

[73] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between healthcare institutions (e.g., from one hospital system to another) and allows robust sharing within a single institution (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital that within the same system).

[74] 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.

[75] Although effective on June 25, 2024, compliance with this rule was required on December 23, 2024, except for the applicable requirements for revising Notice of Policy Practices (as required by 45 C.F.R. § 164.520), which must be complied with by February 16, 2026.

[76] 42 U.S.C. § 164.502(a)(5)(iii). *See also HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html (content last reviewed April 22, 2024).

[77] 42 U.S.C. § 164.509. The U.S. Department of Health & Human Services (HHS) recently released a model attestation, available here: https://www.hhs.gov/sites/default/files/model-attestation.pdf.

[78] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).

[79] 42 U.S.C. § 164.502(a)(5)(iii).

[80] American Medical Association, *HIPAA Privacy Rule to Support Reproductive Health Care Privacy AMA Drafted*

Summary of Regulatory Changes in Final Rule (April 26, 2024), https://www.ama-assn.org/system/files/summary-regulatory-changes-final-rule-reproductive-health-information.pdf (last visited June 27, 2024).

[81] *Tennessee et al. v. U.S. Dept. of Health & Human Servs., et al*, No. 3:25-cv-00025 (E.D. Tenn. Jan. 17, 2025); *Texas v. U.S. Dept. of Health & Human Servs., et al*, No. 5:24-cv-00204-H (N.D. Tex. Sept. 4, 2024); *Purl v. U.S. Dept. of Health & Human Servs., et al.*, No. 2:24-cv-00228-Z (N.D. Tex. Dec. 22, 2024) (enjoining the 2024 HIPAA Rule as to Dr. Purl only).

[82] 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). 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. HHS intends to expand disincentives to other groups of health care providers in future rulemaking.

[83] In addition to the federal government, some states have taken steps to address vulnerabilities in this information sharing, specifically for abortion and gender-affirming care. For example, in 2023, Maryland and California passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure.

[84] S.D. CODIFIED LAWS § 34-23A-11.

[85] *Id.* § 36-4-47. This restriction on medication abortion was preliminarily enjoined, but the injunction was vacated on July 22, 2022, re-instating enforcement of the restriction. *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Noem*, No. 22-1362, 2022 WL 3449758, at *1 (8th Cir. July 22, 2022).

[86] S.D. CODIFIED LAWS §§ 36-4-47; 34-23A-57.

[87] *Id.* § 36-4-47.

[88] *Id.*

[89] *Id.*

[90] *Id.* § 36-11-70.

[91] *Id.* § 34-23A-17.