



ABORTION
DEFENSE
NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

TENNESSEE

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 August 2025

Key Takeaways

Providing contraception, including emergency contraception, is legal.

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

Providing information to adults about how to obtain a legal abortion in another state is legal. Tennessee law forbids providing certain support to minors seeking a legal abortion in another state without written and notarized parental consent. Litigation regarding that law is ongoing.

Abortion is prohibited under Tennessee law unless the patient has a qualifying medical emergency, meaning abortion is necessary to “prevent the death” of the patient or to “prevent serious risk of substantial and irreversible impairment of a major bodily function.” Litigation seeking clarification of the exception is ongoing.

Definition of Abortion & Contraception

ABORTION

The legal definition of abortion in Tennessee is “the use of any instrument, medicine, drug, or any other substance or device with intent to terminate the pregnancy of a woman known to be pregnant with intent other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, to terminate an ectopic or molar pregnancy, or to remove a dead fetus.”¹ The state defines “pregnant” as “the human female reproductive condition of having a living unborn child within her body throughout the entire embryonic and fetal stages of the unborn child from fertilization until birth.”²

This means that the following terminations are not abortions under Tennessee law: (1) removal of an ectopic pregnancy; (2) removal of a molar pregnancy; and (3) removal of a “dead fetus.” While undefined, it is generally understood that the term “dead” means that there is no cardiac activity present in the embryo or fetus.³ As a result, treatment for an incomplete miscarriage is not considered an abortion under Tennessee law and is therefore not prohibited by Tennessee’s abortion bans as long as there is no embryonic or fetal cardiac activity when care is provided.

Tennessee law does not contain specific medical requirements related to miscarriage care or treatment following a stillbirth.⁴ Provided that an embryo or fetus does not have detectable cardiac activity, Tennessee law permits all necessary treatment and medical management following a miscarriage, including use of intact D&E. Further, Tennessee law does not require that a parent or guardian of a young person under 18 consent before the patient may obtain necessary miscarriage treatment.⁵

With respect to self-managed abortion, it is legal for providers to give medical care to a pregnant person who has initiated or recently completed a self-managed abortion provided there is no embryonic or fetal cardiac activity or the patient is experiencing a complication that would qualify as a medical emergency (see below). A pregnant person cannot be convicted under Tennessee’s abortion ban for self-managing their abortion, because the state’s criminal abortion ban explicitly exempts pregnant people from liability.⁶

CONTRACEPTION

Contraception is not illegal in any state in the country. Tennessee law permits the provision and use of all contraceptives, including intrauterine devices and emergency contraceptives such as Plan B. “Contraceptive supplies” are defined as “medically approved items designed to prevent conception through chemical, mechanical or other means.”⁷ “Contraceptive procedures” are defined as “any medically accepted procedure designed to prevent conception.”⁸ Tennessee defines “abortion-inducing drug,” “abortion,” and “chemical abortion” in a manner which would seem to exclude drugs that are used to *prevent* pregnancy, like emergency contraception.⁹

Abortion Bans

Trigger Ban: Tennessee began enforcing its trigger ban on August 25, 2022, approximately two months after the U.S. Supreme Court’s decision and one month after issuance of the judgment in *Dobbs v. Jackson Women’s Health Organization*.¹⁰ The trigger ban prohibits performing or attempting to perform an abortion at any gestational age.¹¹ The only exception to the ban is if a licensed physician performs an abortion in a licensed hospital or ambulatory surgical treatment center after the physician determines, in their reasonable medical judgment, that the pregnant person is experiencing a medical emergency (explained in more detail below).¹² It is not a

violation of Tennessee's abortion ban if a licensed physician provides medical treatment to a pregnant person "which results in the *accidental* death or *unintentional* injury to or death of the unborn child."¹³

Providing an abortion that violates Tennessee's trigger ban is a Class C felony¹⁴ punishable by three to fifteen years' imprisonment and up to a \$10,000 fine.¹⁵

Other Bans and Restrictions: Tennessee's trigger ban explicitly supersedes Tennessee's other gestational age and reason-based abortion bans,¹⁶ which include gestational age bans at six,¹⁷ eight, ten, twelve, fifteen, eighteen, twenty, twenty-one, twenty-two, twenty-three, and twenty-four weeks after a patient's last menstrual period;¹⁸ a ban after viability of a fetus;¹⁹ and a ban on abortion if the physician knows the abortion is sought due to the race, sex, or diagnosis or potential diagnosis of Down syndrome in the fetus.²⁰ Although these bans are currently superseded and therefore not currently in effect,²¹ they remain on the books and can spring back into effect if the trigger ban is ever enjoined.²²

Additionally, Tennessee law prohibits intact D&E procedures (sometimes called D&X procedures)²³ and continues to include requirements that pregnant people who seek abortion care must undergo a mandatory forty-eight hour waiting period²⁴ and counseling.²⁵ The state maintains prohibitions on public funding for abortions²⁶ and prohibits private insurance coverage purchased through the state's health insurance exchange from covering abortions.²⁷ Finally, Tennessee continues to require that a parent, legal guardian, or judge consent to an abortion for a young person under 18.²⁸ It is possible that these laws do not apply if an abortion meets the medical emergency exception, but as explained below, it is not clear whether that will always be the case.²⁹

"Medical Emergency" Exception to Abortion Bans

The only exception to Tennessee's abortion ban is for medical emergencies due to specific medical conditions.³⁰ A Tennessee court temporarily blocked the vague medical emergency standard and identified specific medical conditions that would qualify as exceptions to the abortion ban.³¹ Tennessee does not have exceptions for rape or incest, and the state legislature rejected proposed legislation to create these exceptions.³²

Language of Exception: Tennessee's trigger ban provides that abortion is legal if: (1) the abortion is performed by a licensed physician; (2) the abortion is provided in either a licensed hospital or an ambulatory surgical treatment center; (3) the physician determines, based on reasonable medical judgment, that the abortion is "necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman;" and (4) when performing the abortion, the physician "provides the best opportunity for the unborn child to survive," unless, in the provider's reasonable medical judgment, "termination of the pregnancy in that manner would pose a greater risk of death to the pregnant woman or substantial and irreversible impairment of a major bodily function."³³

Tennessee law specifically provides that the medical emergency exception to the abortion ban does *not* apply if the provider's determination that the pregnant person's life or health is at serious risk is based on "a claim or a diagnosis that the pregnant woman will engage in conduct that would result in her death or the substantial and irreversible impairment of a major bodily function or for any reason relating to the pregnant woman's mental health."³⁴ Thus, the provider may only provide an abortion under Tennessee's trigger ban if the

pregnant person's physical health is at serious risk from a cause other than suicide or self-harm.

Interpretation of Exception: The medical emergency exception does not require that the risk of death or serious impairment of a major bodily function be imminent. It does, however, require that the impairment of the major bodily function be “substantial and irreversible.”³⁵ A Tennessee court has determined that the following medical conditions fall within the medical necessity exception:

- Previaible preterm premature rupture of membranes (“PPROM”);
- Dilation of the cervix prior to viability of the pregnancy, either by preterm labor or cervical insufficiency; and
- Fatal fetal diagnoses that lead to maternal health complications, such as severe preeclampsia or mirror syndrome associated with fetal hydrops, or maternal infection that will result in uterine rupture and the possible loss of the patient's fertility.³⁶

The conditions are part of a temporary injunction against the broad language of the abortion ban, and thus this list of exceptions is subject to change pending a final ruling. The lawsuit seeks to clarify the scope of the medical exception in a more permanent way and is currently pending in Tennessee state court.³⁷

Legal Requirements in Emergencies: When a provider acts to save the life of a pregnant person or prevent substantial and irreversible impairment to a major bodily function, other abortion restrictions in Tennessee's code may not apply. The following provisions of Tennessee law also have exceptions in the event of a medical emergency: the prohibition on intact D&E procedures (sometimes called D&X procedures);³⁸ informed consent counseling and

mandatory 48-hour delay requirements;³⁹ and Tennessee's parental consent law for young people under 18 seeking abortion care.⁴⁰ However, each of these exceptions are defined somewhat differently than the Tennessee trigger ban's medical emergency exception. For example, Tennessee's ban on intact D&E procedures does not apply if the patient's “life is endangered,” while Tennessee's trigger ban only permits abortion provision when there is a “serious risk of substantial and irreversible impairment of a major bodily function.”⁴¹ Similarly, the informed consent law's medical emergency exception only applies if the patient's need for an abortion is “immediate.”⁴² And the parental consent exception applies if a medical emergency “so complicates” a pregnancy such that an “immediate abortion” is required.⁴³ Because exceptions to Tennessee's abortion laws vary throughout the code, it is unclear when—if ever—individual restrictions apply notwithstanding an emergency under the state's trigger ban. Litigation is ongoing to determine the scope of the medical emergency exception.

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.⁴⁴ 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.”⁴⁵ 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.”⁴⁶

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,⁴⁷ including people in labor or with emergency pregnancy complications,⁴⁸ unless the individual refuses to consent to such treatment.⁴⁹ 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.”⁵⁰ 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.⁵¹ 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.”⁵²

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.⁵³

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.”⁵⁴ 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.”⁵⁵ 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.”⁵⁶ 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.⁵⁷

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.⁵⁸ 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].”⁵⁹ 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.⁶⁰ That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.⁶¹ Following the change of presidential administrations, the United States dismissed that case entirely.⁶²

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.⁶³ As a result, the Fifth Circuit's decision is final.^{64 65}

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: (1) the right to be informed of their health status; (2) be involved in care planning and treatment; and (3) participate in the development of their plan of care.⁶⁶

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.⁶⁷

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.⁶⁸

Resident Training: The Accreditation Council for Graduate Medical Education ("ACGME") requires that accredited programs provide access to training in the provision of abortion.⁶⁹ 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.

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.⁷⁰ 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 under Tennessee's abortion ban.⁷¹

The only abortion-specific reporting requirements under Tennessee law are:

Induced Termination & Fetal Tissue Disposition

Reporting: Under Tennessee law, a physician providing an abortion must keep a record of each abortion and a record "of the disposition of the aborted fetus or aborted fetal tissue" for each abortion.⁷² There is no such requirement for treatment for ectopic and molar pregnancies as these conditions are exempted from the definition of "abortion" under Tennessee law.⁷³ Additionally, there is no reporting requirement for medication abortions where "the expulsion of the aborted fetus or aborted fetal tissue does not take place at the facility or clinic."⁷⁴

Where reporting is required, each abortion must be reported to the Commissioner of Health.⁷⁵ The reports must be made within ten days after the abortion is provided.⁷⁶ If the abortion is a procedural rather than medication abortion, the provider must include information in the report of the location of the fetal or embryonic tissue, including the name and address of the third party who will be disposing of the tissue.⁷⁷ The reports that are provided to the Commissioner of Health are consolidated and reported quarterly to the Governor, the Speaker of the Senate, the Speaker of the House of Representatives, and the chairs of the Health and Welfare Committee of the Senate and the Health Committee of the House of Representatives.⁷⁸

Sexual Abuse Reporting in the Context of Abortions: Tennessee law requires providers to report suspected child abuse if they have been asked to provide an abortion for a young person under thirteen years old and they have reasonable cause to believe the young person is a victim of sexual abuse.⁷⁹ The physician must “also notify the official to whom the report is made of the date and time of the scheduled abortion” and provide an extraction of the fetal or embryonic tissue to law enforcement for the purpose of “conducting the investigation into the rape of the minor.”⁸⁰

Complication Reporting: The Tennessee Department of Health keeps track of data related to “the number” and “types” of complications of induced abortions.⁸¹ Tennessee does not obligate individual healthcare providers to report abortion-related complications to the state.

Fetal Death Reporting: Tennessee requires medical providers to report fetal deaths to the state’s Office of Vital Records if: (1) the fetus weighs 350 grams or more, or (2) the gestational age is greater than twenty weeks.⁸² Reports must be made within ten days after delivery.⁸³ If the death occurs within a hospital or other institution, the institution must

report the death.⁸⁴ If the death occurs outside of an institution, “the physician in attendance at or immediately after the delivery” must prepare and file the report.⁸⁵ Finally, if a fetal death occurs without medical attendance, the medical examiner must investigate the cause and report the death accordingly.⁸⁶ The fetal death reporting law does not mention abortion.

Other Mandatory Reporting: Tennessee’s general mandatory reporting requirements to the Department of Children’s Services, local law enforcement, etc., also apply for abortion patients.⁸⁷ This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse.

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.⁸⁸ 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.⁸⁹

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.⁹⁰ 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.⁹¹ 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.⁹² 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.⁹³ 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.⁹⁴ The rule only applies to healthcare providers who are subject to HIPAA.⁹⁵ Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.⁹⁶

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.⁹⁷ 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.⁹⁸

Counseling & Referral

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

Tennessee law also provides that no physician shall be required to provide or participate in the performance of an abortion, and no hospital shall be required to permit abortions to be performed therein.⁹⁹

In March 2023, the United States Department of Health and Human Services revoked Tennessee’s Title X funding because Tennessee Department of Health policy prohibited Title X clinics from counseling patients about pregnancy termination outside of the narrow exceptions in the state’s abortion ban.¹⁰⁰ The Tennessee Department of Health took the position that Title X clinics were only permitted to counsel patients about “options that are legal in the State of Tennessee[.]” which

eliminated abortion in nearly all circumstances.¹⁰¹ Despite losing federal funding, the Tennessee Department of Health has not changed its policy regarding abortion referral in Title X clinics.¹⁰² It’s unclear whether the Trump Administration will reinstate Tennessee’s Title X funds.¹⁰³

Assisting Young People: On July 1, 2024, Tennessee’s abortion assistance ban for young people under 18 (unemancipated minors) took effect.¹⁰⁴ This law prohibits adults from “intentionally recruit[ing], harbor[ing], or transport[ing] a pregnant unemancipated minor” within the state of Tennessee without the written notarized consent of the minor’s parent or guardian if, in engaging in these activities, the adult has at least one of three purposes: (1) concealing an abortion from the minor’s parents or guardian; (2) procuring “an act that would constitute” an abortion for the pregnant minor, even if abortion is lawful in the state where the care is to be provided; or (3) obtaining abortion medications for a pregnant minor, even if abortion is lawful in the state where the medications are obtained.¹⁰⁵ The terms “recruit,” “harbor,” and “transport” are undefined, leading to confusion as to what exactly would constitute an offense under this law. Violation is punishable by imprisonment for eleven months and twenty-nine days.¹⁰⁶

The assistance ban is currently the subject of two lawsuits that assert that the statute is vague and violates the First Amendment.¹⁰⁷ In one of the two lawsuits, a federal court temporarily blocked the enforcement of the law’s “recruitment” provision.¹⁰⁸ This permits Tennesseans to share information about how to obtain an abortion out of state for unemancipated minors. However, the law’s “harbor” and “transport” provisions remain in effect and prohibit direct assistance, such as driving a minor or assisting a minor with lodging to obtain an abortion out of state.

Medication Abortion

Tennessee law defines “chemical abortion” as “the use or prescription of an abortion-inducing drug dispensed with intent to cause the death of the unborn child.”¹⁰⁹ Like Tennessee’s gestational bans, the state’s ban on abortion medications is superseded by its trigger ban, which bans abortion in most cases. Therefore, it is no longer in effect as long as the trigger ban is in effect.¹¹⁰

Disposition of Fetal Tissue Remains

Tennessee law requires abortion facilities—including ambulatory surgical treatment centers, private offices, or other facilities in which abortion is legally provided—to comply with specific requirements related to the disposition of embryonic and fetal tissue.¹¹¹ Specifically, fetal remains from a procedural abortion must be disposed of by

cremation in a licensed crematory facility or by interment.¹¹² The pregnant person may choose to have the tissue disposed of by cremation or interment and may also choose the location for the final disposition.¹¹³ The pregnant person’s choice must be provided in writing, and must indicate whether the final disposition of the fetal remains will be at the abortion facility or another location.¹¹⁴ If the pregnant person does not make a selection, the abortion facility can decide whether to select cremation or interment.¹¹⁵ The abortion facility is required to pay for and provide for the cremation or interment of fetal remains unless the disposition determination made by the pregnant person “identifies a location for final disposition other than a location provided by the abortion facility.”¹¹⁶ Tennessee’s tissue disposition requirements only apply to “surgical abortion[s] that occur[] at an abortion facility” and explicitly excludes procedural abortions provided at hospitals.¹¹⁷

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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References

¹ TENN. CODE ANN. [§ 39-15-213\(a\)\(1\)](#).

² *Id.* [§ 39-15-213\(a\)\(3\)](#).

³ *See, e.g., id.* [§ 39-15-214\(a\)\(7\)](#) (describing “[t]he presence of a fetal heartbeat” as “medically significant because the heartbeat is a discernible sign of life at every stage of human existence”); *id.* [§ 39-15-214\(a\)\(12\)](#) (“By the beginning of the second trimester, physicians view the absence of a fetal heartbeat as an instance of fetal death.”).

⁴ While Tennessee does not restrict types of medical care available to treat stillbirth, providers must file a “fetal death report” for “[e]ach fetal death of three hundred fifty (350) grams or more or of twenty (20) completed weeks’ gestation or more[] that occurs in th[e] state.” *Id.* [§ 68-3-504\(a\)\(1\)](#).

⁵ *See id.* [§ 37-10-302](#) (excluding the removal of “a dead fetus” from the definition of abortion under Tennessee’s parental consent law).

⁶ *Id.* [§ 39-15-213\(e\)](#) (“This section does not subject the pregnant woman upon whom an abortion is performed or attempted to criminal conviction or penalty.”).

⁷ *Id.* [§ 68-34-102\(3\)](#).

⁸ *Id.* [§ 68-34-102\(2\)](#).

⁹ *Id.* [§ 63-6-1102\(2\)\(A\)](#) (defining abortifacients as any “medicine, drug, or other substance provided with the intent of terminating the clinically diagnosable pregnancy of a patient”) (emphasis added); *id.* [§ 39-15-213\(3\)](#) (defining pregnancy as beginning at fertilization); *id.* [§ 39-15-218\(a\)\(2\)](#); *see also* Daniel Dale, *Fact Check: Tennessee Didn’t Ban Plan B Morning-After Pill*, CNN (May 10, 2022, 8:01 AM), <https://www.cnn.com/2022/05/10/politics/fact-check-tennessee-plan-b/index.html>.

¹⁰ TENN. CODE ANN. [§ 39-15-213](#); *id.* [§ 39-15-214](#) (stating that the abortion ban will be “effective on the thirtieth day after issuance of a judgment overruling, in whole or in part, *Roe v. Wade*, as modified by *Planned Parenthood v. Casey*”); *Tennessee*, CTR. FOR REPROD. RTS., <https://reproductiverights.org/maps/state/tennessee/> (last visited Mar. 4, 2025).

¹¹ TENN. CODE ANN. [§ 39-15-213\(b\)](#).

¹² *Id.* [§ 39-15-213\(c\)\(1\)\(A\)](#).

¹³ *Id.* [§ 39-15-213\(d\)](#) (emphasis added).

¹⁴ *Id.* [§ 39-15-213\(b\)](#).

¹⁵ *Id.* [§ 40-35-111\(b\)\(3\)](#).

¹⁶ *Id.* [§ 39-15-213\(f\)](#) (stating the intent to supersede Tennessee’s other abortion restrictions).

¹⁷ *Id.* [§ 39-15-216\(c\)\(1\)](#) (forbidding performing, inducing, or attempting to perform or induce an abortion if embryonic or fetal cardiac activity can be detected); *id.* [§ 39-15-216\(c\)\(2\)](#) (forbidding performing, inducing, or attempting to perform or induce an abortion “upon a pregnant woman whose unborn child is six (6) weeks gestational age or older” unless the provider determines there is no embryonic or fetal cardiac activity).

¹⁸ *Id.* [§ 39-15-216\(c\)\(3\)-\(c\)\(12\)](#); *see also id.* [§ 39-15-212\(a\)](#) (prohibiting abortion “after the beginning of the twentieth week of pregnancy, as measured by gestational age”).

¹⁹ *Id.* [§ 39-15-216\(d\)\(2\)](#); *see also id.* [§ 39-15-211\(b\)\(1\)](#).

²⁰ *Id.* [§ 39-15-217\(b\)-\(d\)](#).

- ²¹ *Id.* [§ 39-15-213\(f\)](#) (“While this section is in effect, this section supersedes §§ 39-15-211, 39-15-212, 39-15-214, 39-15-215, 39-15-216, 39-15-217, and 39-15-218.”).
- ²² *Tennessee*, CTR. FOR REPROD. RTS., <https://reproductiverights.org/maps/state/tennessee/> (last visited Mar. 4, 2025) (“Tennessee has not repealed other laws related to abortion.”).
- ²³ TENN. CODE ANN. [§ 39-15-209\(b\)](#).
- ²⁴ *Id.* [§ 39-15-202\(d\)\(1\)](#).
- ²⁵ *Id.* [§ 39-15-202\(b\)](#).
- ²⁶ *Id.* [§ 9-4-5116](#).
- ²⁷ *Id.* [§ 56-26-134](#).
- ²⁸ *Id.* [§ 37-10-303\(a\)–\(b\)](#). The requirement of parental consent is only waived if the parent is facing charges of incest. *Id.* [§ 37-10-303\(c\)](#).
- ²⁹ *Id.* [§ 39-15-202\(a\)](#) (stating that the informed consent and waiting period requirements apply “[e]xcept in a medical emergency that prevents compliance”); *id.* [§ 9-4-5116\(2\)](#) (permitting the use of public funds for abortion if the patient is “in danger of death unless the abortion is performed”); *id.* [§ 37-10-303\(a\)\(1\)](#) (stating that the requirement of informed consent is waived if failure to retain consent “was due to a bona fide, imminent medical emergency to the minor”).
- ³⁰ *Id.* [§ 39-15-213\(a\)\(1\), \(c\)](#).
- ³¹ *Ruling Temporarily Blocking Tennessee’s Abortion Ban Means Doctors Can Treat Patients Facing Dangerous Pregnancy Complications*, CTR. FOR REPROD. RTS. (Oct. 18, 2024), <https://reproductiverights.org/blackmon-v-tennessee-abortion-ban-temporarily-blocked/>.
- ³² Adam Mintzer, *Bill Narrowly Scaling Back Abortion Ban Passes TN House; Attempts to Add Rape, Incest Exceptions for Minors Fails*, WKRN NEWS, <https://www.wkrn.com/news/tennessee-politics/bill-narrowly-scaling-back-abortion-ban-passes-tn-house-attempts-to-add-rape-incest-exceptions-for-minors-fails> (last updated Mar. 21, 2023).
- ³³ TENN. CODE ANN. [§ 39-15-213\(c\)\(1\)](#). Though different health-related exceptions are stated in different parts of the code, the exception that applies to Tennessee’s trigger ban governs providers’ liability unless and until it is enjoined.
- ³⁴ *Id.* [§ 39-15-213\(c\)\(2\)](#).
- ³⁵ *Id.* [§ 39-15-213\(c\)\(1\)\(A\)](#).
- ³⁶ *Blackmon v. State*, No. 23-1196-IV(I), slip op. at 31–32 (Tenn. Ch. Ct. 20th Jud. Dist., Davidson Cnty. Oct. 17, 2024) (granting preliminary injunction, in part).
- ³⁷ Plaintiffs’ Compl. for Declaratory Judgment & Permanent Injunction, *Blackmon v. State*, No. 23-1196-1 (Tenn. Ch. Ct. 20th Jud. Dist. filed Sept. 11, 2023).
- ³⁸ TENN. CODE ANN. [§ 39-15-209\(c\)](#) (providing that the prohibition does not apply “to a partial-birth abortion that is necessary to save the life of the mother whose life is endangered by a physical disorder, illness or injury”).
- ³⁹ *Id.* [§ 39-15-202\(d\)–\(f\)](#) (excepting abortions provided in medical emergencies from the counseling and delay requirements and defining “medical emergency” as a condition that, “on the basis of the physician’s good faith medical judgment, so complicates a medical condition of a pregnant woman as to necessitate an immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function”).
- ⁴⁰ *Id.* [§ 37-10-305](#) (providing that a provider is not obligated to obtain consent of the young person’s parent or guardian “when, in the best medical judgment of the physician . . . a medical emergency exists that so complicates the pregnancy as to require an immediate abortion”).

- ⁴¹ Compare *id.* § 39-15-209(c), with *id.* § 39-15-213(c)(1)(A).
- ⁴² Compare *id.* § 39-15-202(d)-(e), (f), with *id.* § 39-15-213(c)(1)(A).
- ⁴³ Compare *id.* § 37-10-305, with *id.* § 39-15-213(c)(1)(A).
- ⁴⁴ EMTALA, 42 U.S.C. § 1395dd(a).
- ⁴⁵ EMTALA, 42 U.S.C. § 1395dd(c)(1)(A).
- ⁴⁶ EMTALA, 42 U.S.C. § 1395dd(c)(1)(B).
- ⁴⁷ EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
- ⁴⁸ EMTALA, 42 U.S.C. § 1395dd(c)(1).
- ⁴⁹ EMTALA, 42 U.S.C. § 1395dd(b)(2).
- ⁵⁰ EMTALA, 42 U.S.C. § 1395dd(c)(3)(A).
- ⁵¹ 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).
- ⁵² EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
- ⁵³ 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>.
- ⁵⁴ Kennedy Letter.
- ⁵⁵ Kennedy Letter.
- ⁵⁶ *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.).
- ⁵⁷ Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
- ⁵⁸ *St. Luke’s Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
- ⁵⁹ *St. Luke’s Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
- ⁶⁰ *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
- ⁶¹ *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
- ⁶² *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
- ⁶³ *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
- ⁶⁴ *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).
- ⁶⁵ 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.
- ⁶⁶ 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

⁶⁷ 42 U.S.C. § 300a-7(c) (2000); *Know Your Rights: Existing Laws May Protect Health Care Professionals Who Provide or Support Abortion From Discrimination in Employment*, NAT'L WOMEN'S L. 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/>.

⁶⁸ TENN. CODE ANN. § 29-26-101, *et seq.*

⁶⁹ *Abortion Training and Education in a Post-Dobbs Landscape*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Feb. 6, 2025), <https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/abortion-training-and-education-in-a-post-dobbs-landscape#:~:text=Since%201996%2C%20the%20Accreditation%20Council,ob%2Dgyn%20residency%20programs13> (“Since 1996, the Accreditation Council for Graduate Medical Education (ACGME) has required integrated opt-out abortion training as a routine experience for ob-gyn residency programs.”).

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 TENN. CODE ANN. § 39-15-213(C) (stating requirements of legal abortions under Tennessee’s abortion ban).

⁷² *Id.* § 39-15-203(a).

⁷³ *Id.* § 39-15-213(a)(1) (defining abortion to exclude terminations of “ectopic or molar pregnanc[ies]”).

⁷⁴ *Id.* § 39-15-203(a).

⁷⁵ *Id.*

⁷⁶ *Id.* § 68-3-505(a).

⁷⁷ *Id.* § 68-3-505(a); *id.* § 39-15-203(b)(2).

⁷⁸ *Id.* § 39-15-203(e).

⁷⁹ *Id.* § 39-15-210(b)(1).

⁸⁰ *Id.*

⁸¹ *Id.* § 68-1-140.

⁸² *Id.* § 68-3-504(a)(1).

⁸³ *Id.*

⁸⁴ *Id.* § 68-3-504(a)(2).

⁸⁵ *Id.* § 68-3-504(a)(3).

⁸⁶ *Id.* § 68-3-504(c).

⁸⁷ 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.

⁸⁸ 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).

⁸⁹ 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.

⁹⁰ 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.

⁹¹ [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).

⁹² 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>.

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

⁹⁴ 42 U.S.C. § 164.502(a)(5)(iii).

⁹⁵ 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).

⁹⁶ *Tennessee v. U.S. Dept. of Health & Human Servs.*, No. 3:25-cv-00025 (E.D. Tenn. Jan. 17, 2025); *Texas v. U.S. Dept. of Health & Human Servs.*, No. 5:24-cv-00204-H (N.D. Tex. Sept. 4, 2024); *Purl v. U.S. Dept. of Health & Human Servs.*, No. 2:24-cv-00228-Z (N.D. Tex. Dec. 22, 2024) (enjoining the 2024 HIPAA Rule as to Dr. Purl only).

⁹⁷ 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.

⁹⁸ 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.

⁹⁹ TENN. CODE. ANN. § 39-15-204.

¹⁰⁰ See Jeff Keeling, *Tennessee to Backfill Title X Family Planning Funding that Feds Pulled Over Abortion*, WJHL, <https://www.wjhl.com/news/local/tennessee-to-backfill-title-x-family-planning-funding-that-feds-pulled-over-abortion> (updated Apr. 12, 2023).

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Catherine Sweeney, *Tennessee's Title X Family Planning Funding Could Change Under a Second Trump Term*, WPLN (Nov. 19, 2024), <https://wpln.org/post/tennessees-title-x-family-planning-funding-could-change-under-a-second-trump-term/>.

¹⁰⁴ S.B. 1971, 113th Gen. Assemb. (Tenn. 2024).

¹⁰⁵ *Id.* § 1(a), (c).

¹⁰⁶ *Id.* § 1(b).

¹⁰⁷ See Compl., *SisterReach, Inc. v. Skremetti*, No. 2:24-cv-02446-SHL-tmp (W.D. Tenn. filed June 27, 2024); Compl., *Welty v. Dunaway*, No. 3:24-cv-00768 (M.D. Tenn. filed June 24, 2024).

¹⁰⁸ *Welty v. Dunaway*, No. 3:24-cv-00768, 2024 WL 4712759, at *23 (M.D. Tenn. Sept. 20, 2024).

¹⁰⁹ TENN. CODE. ANN. § 39-15-218(a)(2).

¹¹⁰ See *id.* § 39-15-213(f).

¹¹¹ *Id.* § 39-15-219(a). Because this section of Tennessee's code was superseded by the state's trigger ban—

which restricts abortion provision to hospitals or ambulatory surgical treatment centers—the other locations mentioned in § 39-15-219(a) are likely no longer relevant.

¹¹² *Id.* [§ 39-15-219\(b\)](#).

¹¹³ *Id.* [§ 39-15-219\(c\)\(1\)](#).

¹¹⁴ *Id.* [§ 39-15-219\(d\)\(1\)](#).

¹¹⁵ *Id.* [§ 39-15-219\(d\)\(2\)](#).

¹¹⁶ *Id.* [§ 39-15-219\(h\)](#). If the patient selects a different location, they are responsible for the costs. *Id.*

¹¹⁷ *Id.* [§ 39-15-219\(a\)\(1\)\(B\)](#), [\(b\)\(1\)](#). Although Tennessee law is not explicit, the fetal disposition requirement does not appear to apply to a medication abortion where the patient passes pregnancy tissue outside the medical facility. *See, e.g., id.* [§ 39-15-219\(c\)\(2\)](#) (stating requirements exclusively for “surgical abortion”); *id.* [§ 39-15-203\(a\)](#) (2023) (providing that, for the purpose of the abortion reporting form, a provider is not required to report the disposition of the fetal tissue if the abortion is a medication abortion and the “expulsion of the aborted fetus or aborted fetal tissue does not take place at the facility or clinic where the procedure took place”). Additionally, because the law defines fetal remains as an “aborted fetus or fetal tissue that results from an abortion of an unborn child[.]” it does not seem to apply to fetal tissue from a miscarriage. *Id.* [§ 39-15-219\(a\)\(4\)](#). As a result, if a provider provides treatment to a patient following a self-managed abortion, they are not required to comply with the requirements related to fetal and embryonic tissue disposition.