ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

VIRGINIA

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.

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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 legal in Virginia through the second trimester of pregnancy.

Abortion is prohibited in Virginia during the third trimester unless continuing the pregnancy would:

(1) result in the pregnant person's death or

(2) "substantially and irremediably impair" the pregnant person's mental or physical health.

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Definition of Abortion & Contraception

ABORTION

Virginia law does not include an explicit definition of "abortion" but generally, Virginia's abortion laws apply to the use of any means to intentionally terminate a pregnancy.[1]

For purposes of vital statistics requirements, Virginia defines "induced termination of pregnancy" as "the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus and which does not result in a live birth."[2] The term "dead fetus" is not defined, but a "fetal death" is defined in the vital statistics laws as not showing "any []evidence of life" after "expulsion or extraction," such as breathing, a heartbeat, umbilical cord pulsation, or "definite movement of voluntary muscles."[3] Additionally, within the abortion context, Virginia defines an "infant who has been born alive" as one exhibiting any "evidence of life," including breathing, a heartbeat, umbilical cord pulsation, or "definite movement of voluntary muscles."[4]

All of this suggests that an "abortion" in Virginia would not include a procedure to remove a "dead fetus," and that "dead" means there is no cardiopulmonary activity present in the embryo or fetus. This means that an 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 Virginia law and thus are not prohibited by Virginia's abortion laws, and no other laws in Virginia prohibit treatment for ectopic pregnancy or a miscarriage where there is no cardiac activity.

With respect to self-managed abortion, Virginia does not have a specific crime of self-managed abortion, and no civil law explicitly prohibiting a person from self-managing an abortion.[5]

CONTRACEPTION

Contraception is not illegal in Virginia (or any state). Virginia uses the term "birth control" for contraception, defining "birth control" as "contraceptive methods that are approved by the U.S. Food and Drug Administration."[6] Virginia law specifies that birth control is not considered abortion for the purpose of Virginia's criminal abortion statutes.[7]

Third Trimester Abortion Ban

Virginia bans abortion in the third trimester of pregnancy, unless continuing the pregnancy is likely to result in the patient's death or "substantially and irremediably impair the mental or physical health" of the patient.[8] These exceptions are discussed in the next section.

The penalties for violating this ban are: (1) criminal: a Class 4 felony, punishable by two to ten years imprisonment and a fine of up to $100,000;[9] and (2) professional: the Virginia Medical Board considers it unprofessional conduct to perform or aid and abet a criminal abortion; penalties can include but are not limited to revocation of a medical license.[10]

Other Abortion Bans and Restrictions: Virginia requires that after viability or during the third trimester, abortions be provided in an outpatient surgical hospital (OSH) or hospital.[11] Prior to the third trimester or pre-viability, Virginia does not impose any specific facility requirements on abortions. The law does not define "trimester."[12]

In the first trimester, abortions must be provided by licensed advance practice registered nurses (APRN) or physicians.[13] In the second and third trimester, abortions must be provided by a licensed physician.[14]

The physician or APRN providing the abortion must obtain the "informed written consent" of the pregnant person (or if the person is incapacitated, another authorized person) prior to the abortion.[15] The law does not have specific requirements for information that must be provided to obtain this consent. Young people under 18 must also obtain written, notarized consent from an "authorized person" (including a parent or guardian) or a court order from a judge through a judicial bypass proceeding to obtain an abortion, unless they meet specific exceptions (including emancipation, abuse or neglect, or a medical emergency).[16]

Virginia also has a ban on intact D&E (sometimes called D&X) procedures.[17]

Medical Exceptions to Abortion Ban and Restrictions

Life and Health Exceptions: Virginia's third trimester abortion ban provides a medical exception if the physician and two consulting physicians certify and document in the patient's medical record that "in their medical opinion, based upon their best clinical judgement" continuing the pregnancy is likely to result in the patient's death or to "substantially and irremediably impair the mental or physical health" of the patient.[18] An abortion provided under this exception must be provided by a licensed physician in an OSH or a hospital and, if there is any "clearly visible evidence of viability," measures for life support for the fetus must be available and utilized.[19]

Virginia law further provides an exception to the parental notice and consent requirements for young people under 18 if, in a physician's good faith clinical judgment, a condition so complicates the medical condition of the pregnant person as to require an "immediate" abortion "to avert [their] death or for which a delay will create a serious risk of substantial and irreversible impairment of a major bodily function."[20]

Unless the abortion is necessary to save the pregnant person's life (see below), abortion providers must still comply with Virginia's written informed consent statute.[21]

Affirmative Defense to Save Pregnant Person's Life: When an abortion is provided "in order to save [the pregnant person's] life, in the opinion of the physician" performing the abortion, certain Virginia laws do not apply.[22]

The laws that do not apply include: facility requirements for abortions provided after viability or during the third trimester; the third trimester requirement to have the physician and two consulting physicians certify that the life or health exceptions were met and having measures for life support if there is clear evidence of viability; and obtaining written informed consent prior to the abortion.[23]

In contrast to an exception, which should prevent a person from being criminally charged in the first place, an affirmative defense is a defense that a defendant, who has already been charged with a crime, can introduce into evidence that, if proven, defeats conviction. It is important to note that an affirmative defense does not mean that a provider will not be sued or arrested in the first place. Rather, this affirmative defense may help a provider defendant be acquitted of charges under Virginia's abortion laws.

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 participating in Medicare and Medicaid to inform patients of their rights before 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]

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

Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it require reporting to law enforcement patients who receive abortions out of state or self-manage their own abortion.[51]

The only abortion-specific documentation and reporting requirements are:

Documentation: For any abortion not necessary to save the patient's life, the abortion provider must obtain the informed written consent of the patient (or, where appropriate, the patient's parent, guardian or other authorized person) prior to the abortion.[52] If the patient is under 18 years old, the provider must obtain written authorization from an authorized person (unless an exception to this requirement is met or the minor obtains a judicial bypass), and that

authorization must be maintained in the patient's record.[53] This requirement does not apply if the abortion is being performed in a medical emergency (discussed above).[54]

As mentioned above, when an abortion is provided in the third trimester, the physician and two consulting physicians must certify and document in the patient's record "that in their medical opinion, based upon their best clinical judgment, the continuation of pregnancy is likely to result in the death of the woman or substantially and irremediably impair the mental or physical health of the woman."[55] This requirement does not apply if the abortion is being performed to save the patient's life.[56]

Medical facilities may impose additional documentation requirements for abortions performed as medical emergencies, such as approvals by an ethical review board. While intended to insulate hospitals from liability, these are not legal requirements.

Induced and Spontaneous Fetal Death Reporting: Virginia defines fetal death to include both spontaneous and induced terminations of pregnancy, regardless of the gestational age.[57] Both spontaneous and induced terminations must be reported within 3 days after the abortion or delivery of the fetus.[58] The medical certification portion of the fetal death report must be completed and signed within 24 hours of the fetal death by the physician in attendance, unless inquiry or investigation by the Office of the Chief Medical Examiner is required.[59] The law specifies that for induced abortions, the forms are not to identify the patient by name.[60]

"The funeral director or person who first assumes custody of a dead fetus or, in the absence of…such person, the hospital representative who first assumes custody of a fetus shall file the fetal death report; in the absence of such a person, the physician or other person in attendance at or after the delivery or abortion shall file the report of fetal death. The person completing the forms shall obtain the personal data from the next of kin or the best qualified person or source available."[61]

The physician or facility attending an individual "who has delivered a dead fetus" must maintain a copy of the fetal death report for one year.[62]

Virginia additionally requires that inpatient hospitals (and certain other inpatient institutions) collect and maintain a record of information required for certificates of birth, death, and reports of fetal death (for both spontaneous and induced abortions) for each patient.[63] The record must be made at the time the patient is admitted from information provided by the patient or, where they cannot provide it, from relatives or other persons who have the required information.[64] Additionally, by no later than the tenth day of each month, inpatient institutions must send the State Registrar a list, on a form provided by the State Registrar, of all fetal deaths occurring in the institution during the preceding month.[65] All records discussed in this paragraph must be maintained for at least 10 years and made available for inspection to the State Registrar upon request.[66]

Other Mandatory Reporting: All general mandatory reporting to the Virginia Department of Social Services, local law enforcement, etc., applies to abortion patients.[67] This includes child and certain vulnerable adult physical, sexual, mental, or emotional abuse or neglect.[68]

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.[69] 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.[70, 71]

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.[72] 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.[73]

Counseling & Referral

Speech about abortion is legal in Virginia and every other state. Medical professionals in Virginia can thus (1) provide accurate options counseling, including about abortion; (2) refer patients to medical providers in states where abortion is legal; and (3) refer patients to medical providers in Virginia for abortion care that is lawful in Virginia.

Virginia has a law that purports to restrict "encouraging or promoting" abortion that is unlawful in Virginia.[74]

Medication Abortion

While some states have laws that apply specifically to medication abortion, Virginia does not.

Disposition of Fetal Tissue Remains

Virginia does not specifically regulate the disposition of embryonic and fetal tissue. Therefore, legal requirements for disposition of medical waste generally should apply. Virginia law does not have any state-specific restrictions regarding fetal tissue donation.

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] *See* Va. Code Ann. § 18.2-71 (except where provided in other statutes, making it a crime if "any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage"). *See also* Va. Code Ann. § 16.1-241(W) (defining "perform an abortion" to mean "to interrupt or terminate a pregnancy by any surgical or nonsurgical procedure or to induce a miscarriage as provides in § 18.2-72, 18.2-73, or 18.2-74").

[2] Va. Code Ann. § 32.1-249.

[3] *Id.*

[4] Va. Code Ann. § 18.2-71.1. *See also* Va. Code Ann. § 32.1-249 (defining "live birth" for purposes of vital statistics in substantially the same way).

[5] Va. Code Ann. §§ 18.2-71–74.1. *See also Commonwealth v. Roberts*, 96 Va. Cir. 378 (2017) (unpublished opinion finding that the criminal abortion statute does not exclude the pregnant person from liability. Note that unpublished opinions are not binding authority in Virginia but may be cited in litigation. Va. Sup. Ct. R. 5A:1(f)).

[6] Va. Code Ann. § 54.1-2900. *See also Nunnally v. Artis*, 254 Va. 247, 251 (1997) (confirming that "'Individuals are … free to practice contraception to further their constitutionally protected choice not to have children.'") (citations omitted).

[7] Va. Code Ann. § 54.1-2900.

[8] Va. Code Ann. § 18.2-74.

[9] Va. Code Ann. §§ 18.2-10, 18.2-71.

[10] Va. Code Ann. § 54.1-2915(6), (20).

[11] Virginia has a law on the books requiring that abortion in the second trimester be provided in a hospital, which Virginia law defines to include outpatient surgical hospitals ("OSH"). Va. Code Ann. § 18.2-73, *see also* Va. Code Ann. §§ 32.1-123, 32.1-127(B)(3) (defining "hospital" to include an OSH). However, in 2019, a federal district court in Virginia permanently enjoined enforcement of this law as to any "non-surgical" second trimester procedures up to viability. *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 705 (E.D. Va. 2019). Under Va. Code Ann. § 54.1-2400.01:1, "surgery" is defined as requiring "the incision or cutting into of tissue." Except for hysterotomies, no abortion procedures, including aspiration, D&E, and induction, involve an incision or cutting into of tissue. Accordingly, there is currently no legal requirement that these procedures take place in an OSH or hospital unless they are provided post-viability or during the third trimester. Va. Code Ann. § 18.2-74.

[12] A 2019 case defined first trimester as "13 weeks and 6 days after last menstrual period or based on an appropriate clinical estimate by a licensed health care provider." *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 678 n. 6 (E.D. Va. 2019). However, this definition was based on a 2017 regulation that has been repealed, 12 Va. Admin. Code 5-412-230(A) (repealed 2020).

[13] Va. Code Ann. § 18.2-72.

[14] Va. Code Ann. §§ 18.2-73, 18.2-74.

[15] Va. Code Ann. § 18.2-76.

[16] Va. Code Ann. § 16.1-241(W).

[17] Va. Code Ann. § 18.2-71.1. The law provides exceptions if the procedure is necessary to prevent the pregnant person's death, "so long as the physician takes every medically reasonable step. . . to preserve the life and health of the infant." The law also specifically exempts the pregnant person from prosecution "for any a criminal offense based on the performance of any act or procedure by a physician in violation" of the statute.

[18] Va. Code Ann. § 18.2-74.

[19] *Id.*

[20] Va. Code Ann. § 16.1-241(W).

[21] Va. Code Ann. § 18.2-74.1.

[22] Va. Code Ann. § 18.2-74.1, *Simopoulos v. Virginia*, 277 S.E.2d 194 (1981), *aff'd,* 462 U.S. 506 (1983) (finding that Va. Code Ann. § 18.2-74.1 affords a provider the benefit of an affirmative defense).

[23] Va. Code Ann. § 18.2-76.

[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] Nat'l Women's Law Ctr., *Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment* (Feb. 9, 2023).
[48] *See, e.g.,* Va. Code Ann. 8.01-581.20.
[49] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).
[50] 42 U.S.C. § 238n.
[51] 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.

[52] Va. Code Ann. §§ 18.2-74.1, 18.2-76.
[53] Va. Code Ann. § 16.1-241(W).
[54] *Id.*
[55] Va. Code Ann. § 18.2-74.
[56] Va. Code Ann. § 18.2-74.1.
[57] Va. Code Ann. § 32.1-249 (defining "fetal death" as "death prior to the complete expulsion or extraction from its mother of a product of human conception, regardless of duration of pregnancy; death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. a. 'Induced termination of pregnancy' means the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus and which does not result in a live birth. b. 'Spontaneous fetal death' means 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.'").
[58] Va. Code Ann. 32.1-264(A).
[59] Va. Code Ann. 32.1-264(C).
[60] Va. Code Ann. 32.1-264(B).
[61] *Id.*
[62] Va. Code Ann. 32.1-264(F).
[63] Va. Code Ann. 32.1-274(A).
[64] *Id.*
[65] Va. Code Ann. 32.1-274(D).
[66] Va. Code Ann. 32.1-274(E).
[67] *See* Va. Code Ann. §§ 32.1-36, 54.1-2967, 63.2-100, 63.2-1501 *et seq.*, 63.2-1600 *et seq*. 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.
[68] *See* Va. Code Ann. §§ 32.1-36, 54.1-2967, 63.2-100, 63.2-1501 *et seq.*, 63.2-1600 *et seq*.
[69] 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).
[70] 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.
[71] 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.
[72] 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.
[73] 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.

[74] Va Code Ann. § 18.2-76.1.