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 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.[24] Stabilizing medical treatment must be provided to individuals experiencing an emergency medical condition,[25] including people in labor or with emergency pregnancy complications.[26] 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."[27] 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.[28] 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."[29] 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."[30] 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."[31] 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."[32] 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.[33] 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.[34]

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.[35] After temporarily staying that injunction,[36] the U.S. Supreme Court lifted the stay and restored the preliminary injunction in June 2024.[37]

Following the change of presidential administrations, the United States dismissed its case, effectively eliminating the injunction entered in that case. [38] 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.[39]

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).[40, 41]

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.[42]

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.[43]

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.[44]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[45] 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.[46]

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.[47]

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.[48] 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.[49] This requirement does not apply if the abortion is being performed in a medical emergency (discussed above).[50]

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."[51] This requirement does not apply if the abortion is being performed to save the patient's life.[52]

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.[53] Both spontaneous and induced terminations must be reported within 3 days after the abortion or delivery of the fetus.[54] 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.[55] The law specifies that for induced abortions, the forms are not to identify the patient by name.[56]

"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."[57]

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.[58]

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.[59] 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.[60] 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.[61] 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.[62]

Other Mandatory Reporting: All general mandatory reporting to the Virginia Department of Social Services, local law enforcement, etc., applies to abortion patients.[63] This includes child and certain vulnerable adult physical, sexual, mental, or emotional abuse or neglect.[64]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[65] 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.[66]

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.[67] 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.[68] 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.[69] 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.[70] 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.[71] The rule only applies to healthcare providers who are subject to HIPAA.[72] Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.[73]

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.[74] 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.[75]

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.[76]

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

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] Va. Code Ann. § 32.1-249.

[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] Va. Code Ann. § 18.2-74.

[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*, 221 Va. 1059 (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(b)(1)(A).

[26] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[27] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[28] 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).
[29] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[30] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[31] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022).
[32] *Id.*
[33] *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.").
[34] 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*, Washington 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).
[35] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[36] *Idaho v. United States*, 144 S. Ct. 541 (Mem) (2024).
[37] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[38] Idaho v. United States, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[39] *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).
[40] 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).
[41] 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.
[42] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[43] 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).
[44] *See, e.g.,* Va Code Ann. 8.01-581.20.
[45] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 17, 2022).
[46] 42 U.S.C. § 238n.
[47] 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.
[48] Va. Code Ann. §§ 18.2-74.1, 18.2-76.
[49] Va. Code. Ann. § 16.1-241(W).
[50] Va. Code. Ann. § 16.1-241(W).
[51] Va. Code Ann. § 18.2-74.
[52] Va. Code Ann. § 18.2-74.1.
[53] 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.'").

[54] Va. Code Ann. 32.1-264(A).

[55] Va. Code Ann. 32.1-264(C).

[56] Va. Code Ann. 32.1-264(B).

[57] Va. Code Ann. 32.1-264(B).

[58] Va. Code Ann. 32.1-264(F).

[59] Va. Code Ann. 32.1-274(A).

[60] Va. Code Ann. 32.1-274(A).

[61] Va. Code Ann. 32.1-274(D).

[62] Va. Code Ann. 32.1-274(F).

[63] *See* Va. Code Ann. §§ 32.1-36, 54.1-2967, 63.2-100, 63.2-1500 *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.

[64] *See* Va. Code Ann. §§ 32.1-36, 54.1-2967, 63.2-100, 63.2-1500 *et seq.*, 63.2-1600 *et seq*.

[65] 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).

[66] 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.

[67] 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 CFR 164.520), which must be complied with by February 16, 2026.

[68] 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).

[69] 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.

[70] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).

[71] 42 U.S.C. § 164.502(a)(5)(iii).

[72] 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).

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

[74] 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.

[75] 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.

[76] Va Code. Ann. § 18.2-76.1.