ABORTION DEFENSE NETWORK

NEW HAMPSHIRE

Know Your State's Abortion Laws

A Guide for Medical Professionals

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 (including cesarean scar 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 permitted under New Hampshire law if:

(1) the gestational age of the fetus is less than 24 weeks LMP;
(2) the fetus has a fetal abnormality incompatible with life; or
(3) an abortion is necessary to preserve the pregnant person's life or to avert a serious risk of substantial and irreversible impairment of a major bodily function

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Definition of Abortion & Contraception

ABORTION

New Hampshire law defines abortion to mean "the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the fetus."[1]

A termination of pregnancy is excluded from the definition of abortion when it is done with the intent to "(1) save the life or preserve the health of the fetus; (2) remove a dead fetus caused by spontaneous abortion; or (3) remove an ectopic pregnancy."[2] While undefined, it is generally understood that in the context of New Hampshire's definition of abortion, "dead" means that there is no cardiac activity present in the embryo or fetus. This means that treatment for miscarriage where there is no cardiac activity (including medications, D&C, D&E, labor induction) is not an abortion under New Hampshire law. Miscarriage care is thus legal when there is no cardiac activity or, as described below, before 24 weeks of pregnancy.

There is not an explicit crime of self-managed abortion in New Hampshire law, and no civil law explicitly prohibits a person from self-managing an abortion.

CONTRACEPTION

The term "contraception" is not defined in New Hampshire law; however, contraception is not illegal in any state in the country.

Abortion Restrictions

24-Week Ban: Under New Hampshire law, abortions are not permitted when the probable gestational age of the fetus has been determined to be at least 24 weeks at the time of the abortion.[3] Gestational age is defined as "the time that has elapsed since the first day of the woman's last menstrual period."[4] In making the determination of gestational age, a health care provider must "make such inquiries of the pregnant woman and perform or cause to be performed all such medical examinations, imaging studies, and tests as a reasonably prudent health care provider in the community, knowledgeable about the medical facts and conditions of both the woman and the fetus involved, would consider necessary to perform and consider in making an accurate diagnosis with respect to gestational age."[5] An ultrasound must be performed prior to the abortion "if the provider either knows that the fetus has a gestational age of at least 24 weeks or is conscious of a substantial risk that the fetus has a gestational age of at least 24 weeks."[6]

A person who knowingly performs or induces an abortion and who knows that the fetus has a gestational age of at least 24 weeks, or who consciously disregards a substantial risk that the fetus has a gestational age of at least 24 weeks, has committed a class B felony,[7] which is punishable by a term of imprisonment of one to seven years.[8] Additionally, violators of the 24-week ban are subject to a fine of at least $10,000 to $100,000.[9] New Hampshire law also allows civil lawsuits against abortion providers who violate the 24-week ban to be brought by the biological father of the fetus (if he was married to the patient at the time of the abortion and the pregnancy is not the result of his criminal conduct), and (if the patient was a minor at the time of the abortion) the patient's parents, unless the parents consented to the minor's abortion.[10] The civil lawsuit against the abortion provider may seek monetary damages for physical and psychological injuries.[11] Any health care provider accused of violating the 24-week ban may seek a hearing by the New Hampshire Board of Medicine as to whether

the physician's conduct was necessary to save the life of the pregnant woman or to prevent a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman,[12] the results of which hearing would be admissible at a civil or criminal trial.[13]

Exceptions to the 24-Week Ban: The 24-week ban contains an exception for medical emergencies.[14] Under New Hampshire law, a medical emergency means "a condition in which an abortion is necessary to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function."[15] Major bodily functions include, but are not limited to, functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.[16]

The 24-week ban also contains an exception for "fetal abnormalities incompatible with life."[17] New Hampshire law does not define which fetal abnormalities are incompatible with life.

Ban on Dilation & Extraction Procedures: New Hampshire prohibits dilation and extraction abortions, a procedure referred to in New Hampshire law as a "partial-birth abortion." The prohibited procedure is defined as "[d]eliberately and intentionally vaginally deliver[ing] a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and . . . [p]erform[ing] the overt act, other than completion of delivery, that kills the partially delivered living fetus."[18]

A person who violates the ban on dilation and extraction procedures "shall be fined not less than $10,000 nor more than $100,000 . . . or be imprisoned not less than one year nor more than 10 years, or both."[19] Additionally, New Hampshire law allows for civil lawsuits against abortion providers who violate the prohibition on dilation and extraction procedures brought by the biological father of the fetus (if he was married to the patient at the time of the abortion and the pregnancy is not the result of his criminal conduct), and (if the patient was a minor at the time of the abortion) the patient's parents, unless the parents consented to the minor's abortion.[20] The civil lawsuit against the abortion provider may seek money damages for physical and psychological injuries and damages equal to three times the cost of the abortion.[21] Any physician accused of violating the prohibition on dilation and extraction procedures may seek a hearing by the New Hampshire Board of Medicine as to whether the physician's conduct was necessary to save the life of the pregnant woman, the results of which hearing would be admissible at a civil or criminal trial.[22]

Exceptions to the Ban on Dilation & Extraction Procedures: A dilation and extraction procedure may be peformed, however, by a physician who "has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself."[23]

Parental Notification: A minor (or an incompetent individual for whom a guardian or conservator has been appointed) may not obtain an abortion until 48 hours after written notice of the abortion has been

delivered to her parent or guardian. Such written notice must be addressed to the parent or guardian's home and personally delivered by the physician or an agent of the physician; alternatively, notice may be made by certified mail with return receipt requested.[24]

The notification requirement may be waived following a hearing before any superior court judge, if: (1) the judge determines that the minor is mature and capable of giving informed consent; or (2) the judge determines that waiver of the notification requirement would be in the minor's best interests.[25]

Parental notification is not required if the abortion provider certifies in the patient's chart that a medical emergency exists and there is not sufficient time to provide the required notice, or if the parent or guardian of the minor certifies that they have already been notified.[26]

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.[27] 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."[28] 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."[29]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[30] including people in labor or with emergency pregnancy complications,[31] unless the individual refuses to consent to such treatment.[32] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[33] A person experiencing an emergency medical condition can 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.[34] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health."[35]

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.[36]

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."[37] 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."[38] 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." [39] 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.[40]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, state officials in Idaho and Texas have attempted to restrict hospitals from complying with their federal legal obligations, resulting in litigation, 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.[41] 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]."[42] 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.[43] 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.[44] Following the change of presidential administrations, the United States dismissed that case entirely. [45]

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.[46] As a result, the Fifth Circuit's decision is final.[47] [48]

Other Federal Laws & Professional Guidelines

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

Conditions of Participation in Medicare and Medicaid (COP): The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: the right to be informed of their health status, be involved in care planning and treatment, and participate in the development of their plan of care.[49]

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.[50]

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.[51]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[52] 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.[53]

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.[54] 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.

New Hampshire law requires abortion-specific reporting in the following circumstances:

24-Week Ban: If a health care provider performs an abortion pursuant to the medical emergency exception to the 24-week ban, they must report, in writing, to the medical facility in which the abortion is performed the reason for the determination that a medical emergency existed. This report must then be included in a written report from the medical facility to the New Hampshire Department of Health and Human Services.

"Medical facility" includes any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.[55]

The health care provider and the medical facility must retain a copy of the written reports for at least five years.[56]

Dilation & Extraction Ban: If a physician performs a dilation and extraction procedure pursuant to the ban's exception, they must report the determination that such a procedure was necessary to preserve the patient's life as well as the reasons for the determination, in writing, to the medical facility in which the abortion was performed; the medical facility must then provide a written report to the Department of Health and Human Services. The physician must retain a copy of the written reports required under this section for at least five years.[57] Failure to comply with this reporting provision will not subject a physician to the criminal and civil penalties under the dilation and extraction procedure ban but may subject them to sanctions, disciplinary action, or any other appropriate action by the New Hampshire Board of Medicine.[58]

Other Mandatory Reporting: All other general mandatory reporting also applies for abortion patients. This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse. Providers must immediately report suspected child abuse or neglect to the New Hampshire Department of Health and Human Services or law enforcement when they have reason to believe a child or a vulnerable adult has suffered abuse.[59]

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.[60] 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.[61, 62]

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.[63] 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.[64]

Counseling & Referral

Speech about abortion is legal in New Hampshire. Medical professionals in New Hampshire can thus provide accurate options counseling, including about abortion, and refer patients to medical providers for abortion care.

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).

ACLU

CENTER for REPRODUCTIVE RIGHTS

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

THE LAWYERING PROJECT

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] N.H. Rev. Stat. Ann. § 329:43(I).
[2] N.H. Rev. Stat. Ann. § 329:43(I)(a)-(c).
[3] N.H. Rev. Stat. Ann. § 329:44(II).
[4] N.H. Rev. Stat. Ann. § 329:43(IV).
[5] N.H. Rev. Stat. Ann. § 329:44(I).
[6] N.H. Rev. Stat. Ann. § 329:44(I).
[7] N.H. Rev. Stat. § 329:46.
[8] N.H. Rev. Stat. § 625:9(III)(a)(2).
[9] N.H. Rev. Stat. § 329:46.
[10] N.H. Rev. Stat. Ann. § 329:47(I).
[11] N.H. Rev. Stat. Ann. § 329:47(II).
[12] N.H. Rev. Stat. § 329:48(I).
[13] N.H. Rev. Stat. Ann. § 329:48(II).
[14] N.H. Rev. Stat. § 329:44(I).

[15] N.H. Rev. Stat. § 329:44(III).
[16] N.H. Rev. Stat. § 329:43(V).
[17] N.H. Rev. Stat. § 329:44(II).
[18] N.H. Rev. Stat. § 329:33(III)(a)-(b).
[19] N.H. Rev. Stat. Ann. § 329:36(II); N.H. Rev. Stat. Ann. § 329:33(IV).
[20] N.H. Rev. Stat. Ann. § 329:37(I).
[21] N.H. Rev. Stat. Ann. § 329:37(I).
[22] N.H. Rev. Stat. Ann. § 329:38(I)-(II).
[23] N.H. Rev. Stat. Ann. § 329:346(II).
[24] N.H. Rev. Stat. § 132:33(I)-(III).
[25] N.H. Rev. Stat. § 132:34(II).
[26] N.H. Rev. Stat. § 132:34(I).
[27] EMTALA, 42 U.S.C. § 1395dd(a).
[28] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[29] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[30] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[31] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[32] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[33] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[34] EMTALA, 42 U.S.C. § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[35] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[36] 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.
[37] Kennedy Letter.
[38] Kennedy Letter.
[39] *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.).
[40] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
[41] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[42] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[43] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[44] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[45] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[46] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[47] *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).

[48] 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.

[49] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[50] Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment, Nat'l Women's Law Ctr. (Feb. 9, 2023), https://nwlc.org/resource/know-your-rights-existing-laws-may-protect-health-care-professionals-who-provide-or-support-abortion-from-discrimination-in-employment/.

[51] N.H. Rev. Stat. § 507-E:2

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

[53] 42 U.S.C. § 238n.

[54] 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.

[55] N.H. Rev. Stat. § 329:43(VI).

[56] N.H. Rev. Stat. § 329:45.

[57] N.H. Rev. Stat. § 329:35(I).

[58] N.H. Rev. Stat. § 329:35(III).

[59] N.H. Rev. Stat. § 169-C:30 (child neglect and abuse); N.H. Rev. Stat. § 169-C:38 (sexual abuse of a minor); N.H. Rev. Stat. § 161-F:46 (abuse of a vulnerable adult)

[60] 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).

[61] 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.

[62] 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 went 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.

[63] 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.

[64] 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.