ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

TENNESSEE

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require so you can advocate for yourself and your patients.

Last updated July 2026

ABORTION DEFENSE NETWORK

TENNESSEE

Key Takeaways

Providing contraception, including emergency contraception, is legal.

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

Providing information about how to obtain a legal abortion in another state is legal. Tennessee passed a law that forbids providing certain support to minors seeking a legal abortion in another state if they lack written, notarized parental consent. However, a federal judge struck down the provision prohibiting information-sharing on obtaining a legal abortion outside of Tennessee.

Abortion is prohibited under Tennessee law unless the abortion is necessary to "prevent the death" of the patient or to "prevent serious risk of substantial and irreversible impairment of a major bodily function," which may include PPROM, "inevitable abortion," severe preeclampsia, mirror syndrome, and infection resulting in uterine rupture or loss of fertility.

Last updated July 2026

ABORTION DEFENSE NETWORK

TENNESSEE

Definition of Abortion & Contraception

ABORTION

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

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

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

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

CONTRACEPTION

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

Abortion Bans

Trigger Ban: Tennessee's trigger ban prohibits performing or attempting to perform an abortion at any gestational age.[10] There is a limited medical emergency exception (explained in more detail below).[11] It is not a violation of Tennessee's abortion ban if a licensed physician provides medical treatment to a pregnant person "which results in the *accidental* death or *unintentional* injury to or death of the unborn child."[12] Tennessee's trigger ban does not have exceptions for rape or incest.[13]

Providing an abortion that violates Tennessee's trigger ban is a Class C felony[14] punishable by three to fifteen years' imprisonment and up to a $10,000 fine.[15]

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

Additionally, Tennessee law prohibits intact D&E procedures (sometimes called D&X procedures)[22] and continues to include requirements that pregnant people who seek abortion care must undergo a mandatory forty-eight hour waiting period[23] and counseling.[24] The state maintains prohibitions on public funding for abortions[25] and prohibits private insurance coverage purchased through the state's health insurance exchange from covering abortions.[26] Finally, Tennessee continues to require that a parent, legal guardian, or judge consent to an abortion for a young person under 18.[27] It is possible that these laws do not apply if an abortion meets the medical emergency exception, but as explained below, it is not clear whether that will always be the case.[28]

"Medical Emergency" Exception to Abortion Ban

The only exception to Tennessee's abortion ban is for medical emergencies due to specific medical conditions.[29] A Tennessee court temporarily blocked the vague medical emergency standard and identified specific medical conditions that would qualify as exceptions to the abortion ban.[30] In April 2025, the Tennessee legislature amended the abortion ban to include the medical emergency exceptions identified by the court.[31]

Language of Exception: Tennessee's trigger ban provides that abortion is legal if: (1) the abortion is performed by a licensed physician; (2) the abortion is provided in either a licensed hospital or an ambulatory surgical treatment center; (3) the physician determines, based on reasonable medical judgment, that the abortion is "necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman;" and (4) when performing the abortion, the physician "provides the best opportunity for the unborn child to survive," unless, in the provider's reasonable medical judgment, "termination of the pregnancy in that manner would pose a greater risk of death to the pregnant woman or substantial and irreversible impairment of a major bodily function."[32]

Tennessee's trigger ban has been amended to clarify the definition of "serious risk of substantial and irreversible impairment of a major bodily function" to mean "any medically diagnosed condition that so complicates the pregnancy of a woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function."[33] This "may include":

- Previable preterm premature rupture of membranes (PPROM);
- inevitable abortion;
- severe preeclampsia;
- mirror syndrome associated with fetal hydrops;
- and an infection that can result in uterine rupture or loss of fertility.[34]

The law also specifically excludes "any condition related to the woman's mental health" from the definition of "serious risk of substantial and irreversible impairment of a major bodily function."[35]

Additionally, Tennessee law specifically provides that the medical emergency exception to the abortion ban does *not* apply if the provider's determination that the pregnant person's life or health is at serious risk is based on "a claim or a diagnosis that the pregnant woman will engage in conduct that would result in her death or the substantial and irreversible impairment of a major bodily function or for any reason relating to the pregnant woman's mental health."[36] Thus, the provider may only provide an abortion under Tennessee's trigger ban if the pregnant person's physical health is at serious risk from a cause other than suicide or self-harm.

Legal Requirements in Emergencies: When a provider acts to save the life of a pregnant person or prevent substantial and irreversible impairment to a major bodily function, other abortion restrictions in Tennessee's code may not apply. The following provisions of Tennessee law also have exceptions in the event of a medical emergency: the prohibition on intact D&E procedures (sometimes called D&X procedures);[37] informed consent counseling and mandatory 48-hour delay requirements;[38] and Tennessee's parental consent law for young people under 18 seeking abortion care.[39] However, each of these exceptions is defined somewhat differently than the Tennessee trigger ban's medical emergency exception. For example, Tennessee's ban on intact D&E procedures does not apply if the patient's "life is endangered by physical disorder, illness or injury," while Tennessee's trigger ban only permits abortion provision when there is a "serious risk of substantial and irreversible impairment of a major bodily function."[40] Similarly, the informed consent law's medical emergency exception only applies if the patient's need for an abortion is "immediate."[41] And the parental consent exception applies if a medical emergency "so complicates" a pregnancy such that an "immediate abortion" is required.[42] Because exceptions to Tennessee's abortion laws vary throughout the code, it is unclear when—if ever—individual restrictions apply notwithstanding an emergency under the state's trigger ban. Despite the clarifying language amending the medical emergency exception in Tennessee's trigger ban, litigation remains ongoing to determine the actual scope of the medical emergency exception.[43]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires the provision of abortion care when necessary to stabilize an emergency medical condition. Specifically, EMTALA requires hospitals with emergency departments that participate in Medicare (i.e., most hospitals) to perform a medical screening exam for any individual who comes to the emergency department and requests evaluation or treatment, in order to determine whether the individual has an emergency medical condition.[44] EMTALA defines "emergency medical condition" to include "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[45] Additionally, "with respect to a pregnant woman who is having contractions," an "emergency medical condition" is further defined to include when "there is inadequate time to effect a safe transfer to another hospital before delivery" or when "transfer may pose a threat to the health or safety of the woman or the unborn child."[46]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[47] including people in labor or with emergency pregnancy complications,[48] unless the individual refuses to consent to such treatment.[49] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[50] A person experiencing an emergency medical condition can be transferred to a different hospital only once they are stable or if certain other conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[51] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health."[52]

Where abortion, including the premature delivery of a non-viable fetus, is the medical treatment necessary to, within a reasonable probability, ensure no material deterioration of an individual's condition, EMTALA requires a covered hospital provide such care or, if the aforementioned criteria are met, an appropriate transfer. The U.S. Department of Health and Human Services ("HHS") has reaffirmed these requirements numerous times.[53]

Most recently, on June 13, 2025, HHS Secretary Robert F. Kennedy distributed a letter to health care providers reiterating that, notwithstanding the recent rescission of earlier guidance on the subject, "EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care."[54] The letter specifically states that EMTALA "applies equally to expectant mothers facing obstetric emergencies, including ectopic pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions."[55] And, during a June 24, 2025, subcommittee hearing in the U.S. House of Representatives, Secretary Kennedy was asked explicitly about whether he agreed that in some circumstances abortion is the necessary stabilizing care that EMTALA requires hospitals to provide, to which he responded, "Yes, and that is what President Trump believes."[56] Further, as recently as May 2025, HHS announced that it had cited at least one hospital in Texas for violating EMTALA by failing to properly screen a patient with an ectopic pregnancy, an emergency medical condition that threatened the patient's life and future fertility.[57]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, state officials in Idaho and Texas have attempted to restrict hospitals from complying with their federal legal obligations, resulting in litigation, but with only varying degrees of success.

In January 2025, Idaho's largest hospital system, St. Luke's Health System, filed a lawsuit seeking to prevent the state of Idaho from enforcing its abortion ban, which creates criminal penalties for the provision of certain emergency abortions required under EMTALA.[58] St. Luke's was successful in obtaining a preliminary injunction that prevents the state of Idaho from enforcing its abortion ban "against St. Luke's or any of its medical providers as applied to medical care required by [EMTALA]."[59] Litigation in that case is ongoing. St. Luke's case is related to one brought in 2022 by the Biden Administration, *United States v. Idaho*, in which the federal government sued Idaho challenging its abortion ban to the extent that it conflicted with EMTALA.[60] That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.[61] Following the change of presidential administrations, the United States dismissed that case entirely.[62]

And, in October 2024, the U.S. Supreme Court

refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of EMTALA in certain circumstances in Texas and as to other organizational plaintiffs in that case.[63] As a result, the Fifth Circuit's decision is final.[64] [65]

Other Federal Laws & Professional Guidelines

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

Conditions of Participation in Medicare and Medicaid ("COP"): The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: (1) the right to be informed of their health status; (2) be involved in care planning and treatment; and (3) participate in the development of their plan of care.[66]

Protection Against Discrimination in Employment: The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against health care providers who participate or are willing to participate in abortion care or sterilization procedures.[67]

Medical Malpractice: While this document does not detail state-specific medical malpractice law, medical providers should be aware that they risk liability under state medical malpractice law for failing to provide pregnant patients with the standard of care.[68]

Resident Training: The Accreditation Council for Graduate Medical Education ("ACGME") requires that accredited programs provide access to training in the provision of abortion.[69] The federal law known as the Coats-Snowe Amendment both protects medical professionals in learning to provide abortion and limits the government's ability to penalize programs or institutions that fail to comply with ACGME requirements.[70]

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.[71] Some hospitals may impose additional documentation requirements for abortions performed as medical emergencies, including attestations by multiple physicians and/or approvals by an ethical review board. While intended to insulate the hospital from liability, these are not legal requirements under Tennessee's abortion ban.[72]

The abortion-specific reporting requirements under Tennessee law are:

Induced Termination & Fetal Tissue Disposition Reporting: Under Tennessee law, a physician providing an abortion must keep a record of each abortion and a record "of the disposition of the aborted fetus or aborted fetal tissue" for each abortion.[73] There is no such requirement for treatment for ectopic and molar pregnancies as these conditions are exempted from the definition of "abortion" under Tennessee law.[74] Additionally, there is no reporting requirement for medication abortions where "the expulsion of the aborted fetus or aborted fetal tissue does not take place at the facility or clinic."[75]

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

Commissioner of Health are consolidated and reported quarterly to the Governor, the Speaker of the Senate, the Speaker of the House of Representatives, and the chairs of the Health and Welfare Committee of the Senate and the Health Committee of the House of Representatives.[79]

Mandatory Reporting in the Context of Abortions: Tennessee law requires providers to report suspected child abuse if they have been asked to provide an abortion for a young person under thirteen years old and they have reasonable cause to believe the young person is a victim of sexual abuse.[80] The physician must "also notify the official to whom the report is made of the date and time of the scheduled abortion" and provide an extraction of the fetal or embryonic tissue to law enforcement for the purpose of "conducting the investigation into the rape of the minor."[81] If the patient is between the ages of 14 and 17, and the provider has reasonable cause to believe the patient is a victim of child sexual abuse, the provider must report the abuse.[82]

Tennessee's general mandatory reporting requirements to the Department of Children's Services, local law enforcement, and others, also apply when a physician is treating abortion patients.[83] This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse.

Complication Reporting: The Tennessee Department of Health keeps track of data related to "the number" and "types" of complications of induced abortions.[84] Tennessee does not obligate individual healthcare providers to report abortion-related complications to the state.

Fetal Death Reporting: Tennessee requires medical providers to report fetal deaths to the state's Office of Vital Records if: (1) the fetus weighs 350 grams or more, or (2) the gestational age is greater than twenty weeks.[85] Reports must be made within ten days after delivery.[86] If the death occurs within a hospital or other institution, the institution must report the death.[87] If the death occurs outside of an institution, "the physician in attendance at or immediately after the delivery" must prepare and file the report.[88] Finally, if a fetal death occurs without medical attendance, the medical examiner must investigate the cause and report the death accordingly.[89] The fetal death reporting law does not mention abortion.

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.[90] 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.[91, 92]

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.[93] 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.[94]

Counseling & Referral

Speech about abortion is legal in Tennessee. Medical

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

Tennessee law also provides that no physician shall be required to provide or participate in the performance of an abortion, and no hospital shall be required to permit abortions to be performed therein.[95]

Assisting Young People: Tennessee has an abortion assistance ban for young people under 18 (unemancipated minors). This law prohibits adults from "intentionally recruit[ing], harbor[ing], or transport[ing] a pregnant unemancipated minor" within the state of Tennessee without the written notarized consent of the minor's parent or guardian if, in engaging in these activities, the adult has at least one of three purposes: (1) concealing an abortion from the minor's parents or guardian; (2) procuring "an act that would constitute" an abortion for the pregnant minor, even if abortion is lawful in the state where the care is to be provided; or (3) obtaining abortion medications for a pregnant minor, even if abortion is lawful in the state where the medications are obtained.[96] The terms "recruit," "harbor," and "transport" are undefined, leading to confusion as to what exactly would constitute an offense under this law. Violation is punishable by imprisonment for eleven months and twenty-nine days.[97]

In a lawsuit challenging the law on First Amendment and Fourteenth Amendment grounds, a federal court struck down the enforcement of the law's "recruitment" provision because it impermissibly restricted constitutionally protected speech.[98] Under this ruling, Tennesseans may share information about how to obtain an abortion out of state for unemancipated minors. However, the law's "harbor" and "transport" provisions remain in effect. Although both terms are vague, the "harbor" and "transport" provisions likely prohibit direct assistance, such as driving a minor, providing funding for a minor, or assisting a minor with lodging to obtain an abortion out of state. However, these activities remain lawful if the adult receives notarized, written consent from the minor's parent or guardian. Additionally, the court order prohibiting enforcement of the "recruitment" provision of the law is currently on appeal. If the appeals court reverses the lower court, the "recruitment" prong could become enforceable again.

Medication Abortion

Tennessee law defines "chemical abortion" as "the use or prescription of an abortion-inducing drug dispensed with intent to cause the death of the unborn child."[99] Like Tennessee's gestational bans, certain additional restrictions on abortion medications are superseded by its trigger ban, which bans abortion in most cases. Therefore, those restrictions specific to abortion medications are not in effect as long as the trigger ban remains in effect.[100] Tennessee maintains other additional regulations for medication abortion,[101] including in-person dispensing requirements,[102] which are *not* superseded by its trigger ban and therefore remain in effect. As of July 1, 2026, the state attorney general may bring a civil action to enforce compliance with these regulations or to impose fines for knowing violations of the in-person distribution requirement. Fines are set at $10,000 per violation or $1 million "if a court determines that an individual suffered serious bodily injury or death."[103]

Disposition of Fetal Tissue Remains

Tennessee law requires abortion facilities—including ambulatory surgical treatment centers, private offices, or other facilities in which abortion is legally provided—to comply with specific requirements related to the disposition of embryonic and fetal tissue.[104] Specifically, fetal remains from a

procedural abortion must be disposed of by cremation in a licensed crematory facility or by interment.[105] The pregnant person may choose to have the tissue disposed of by cremation or interment and may also choose the location for the final disposition.[106] The pregnant person's choice must be provided in writing, and must indicate whether the final disposition of the fetal remains will be at the abortion facility or another location.[107] If the pregnant person does not make a selection, the abortion facility can decide whether to select cremation or interment.[108] The abortion facility is required to pay for and provide for the cremation or interment of fetal remains unless the disposition determination made by the pregnant person "identifies a location for final disposition other than a location provided by the abortion facility."[109] Tennessee's tissue disposition requirements only apply to "surgical abortion[s] that occur[] at an abortion facility" and explicitly exclude procedural abortions provided at hospitals.[110]

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

THE LAWYERING PROJECT

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

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] TENN. CODE ANN. § 39-15-213(a)(1).
[2] *Id.* § 39-15-213(a)(3).
[3] *See, e.g.*, *id.* § 39-15-214(a)(7) (describing "[t]he presence of a fetal heartbeat" as "medically significant because the heartbeat is a discernible sign of life at every stage of human existence"); *id.* § 39-15-214(a)(12) ("By the beginning of the second trimester, physicians view the absence of a fetal heartbeat as an instance of fetal death.").
[4] While Tennessee does not restrict types of medical care available to treat stillbirth, providers must file a "fetal death report" for "[e]ach fetal death of three hundred fifty (350) grams or more or of twenty (20) completed weeks' gestation or more[] that occurs in th[e] state." *Id.* § 68-3-504(a)(1).
[5] *See id.* § 37-10-302(1) (excluding the removal of "a dead fetus" from the definition of abortion under Tennessee's parental consent law).
[6] *Id.* § 39-15-213(e) ("This section does not subject the pregnant woman upon whom an abortion is performed or attempted to criminal conviction or penalty.").
[7] *Id.* § 68-34-102(3).
[8] *Id.* § 68-34-102(2).

[9] *Id.* § 63-6-1102(2)(A) (defining abortifacients as any "medicine, drug, or other substance provided with the intent of terminating the clinically diagnosable *pregnancy* of a patient") (emphasis added); *id.* § 39-15-213(4) (defining pregnancy as beginning at fertilization); *id.* § 39-15-218(a)(2); *see also* Daniel Dale, *Fact Check: Tennessee Didn't Ban Plan B Morning-After Pill*, CNN (May 10, 2022, 8:01 AM), https://www.cnn.com/2022/05/10/politics/fact-check-tennessee-plan-b/index.html.
[10] TENN. CODE ANN. § 39-15-213(b).
[11] *Id.* § 39-15-213(c)(1)(A).
[12] *Id.* § 39-15-213(d) (emphasis added).
[13] Adam Mintzer, *Bill Narrowly Scaling Back Abortion Ban Passes TN House; Attempts to Add Rape, Incest Exceptions for Minors Fails*, WKRN NEWS , https://www.wkrn.com/news/tennessee-politics/bill-narrowly-scaling-back-abortion-ban-passes-tn-house-attempts-to-add-rape-incest-exceptions-for-minors-fails (last updated Mar. 21, 2023).
[14] *Id.* § 39-15-213(b).
[15] *Id.* § 40-35-111(b)(3).
[16] *Id.* § 39-15-213(f) (stating the intent to supersede Tennessee's other abortion restrictions).
[17] *Id.* § 39-15-216(c)(1) (forbidding performing, inducing, or attempting to perform or induce an abortion if embryonic or fetal cardiac activity can be detected); *id.* § 39-15-216(c)(2) (forbidding performing, inducing, or attempting to perform or induce an abortion "upon a pregnant woman whose unborn child is six (6) weeks gestational age or older" unless the provider determines there is no embryonic or fetal cardiac activity).
[18] *Id.* § 39-15-216(c)(3)-(c)(12); *see also id.* § 39-15-212(a) (prohibiting abortion "after the beginning of the twentieth week of pregnancy, as measured by gestational age").
[19] *Id.* § 39-15-216(d)(2); *see also id.* § 39-15-211(b)(1).
[20] *Id.* § 39-15-217(b)–(d).
[21] *Id.* § 39-15-213(f) ("While this section is in effect, this section supersedes §§ 39-15-211, 39-15-212, 39-15-214, 39-15-215, 39-15-216, 39-15-217, and 39-15-218.").
[22] TENN. CODE ANN. § 39-15-209(b).
[23] *Id.* § 39-15-202(d)(1).
[24] *Id.* § 39-15-202(b).
[25] *Id.* § 9-4-5116.
[26] *Id.* § 56-26-134.
[27] *Id.* § 37-10-303(a)–(b). The requirement of parental consent is only waived if the parent is facing charges of incest. *Id.* § 37-10-303(c).
[28] *Id.* § 39-15-202(a) (stating that the informed consent and waiting period requirements apply "[e]xcept in a medical emergency that prevents compliance"); *id.* § 9-4-5116(2) (permitting the use of public funds for abortion if the patient is "in danger of death unless the abortion is performed"); *id.* § 37-10-303(a)(1) (stating that the requirement of informed consent is waived if failure to retain consent "was due to a bona fide, imminent medical emergency to the minor").
[29] *Id.* § 39-15-213(a)(1), (c).
[30] *Ruling Temporarily Blocking Tennessee's Abortion Ban Means Doctors Can Treat Patients Facing Dangerous Pregnancy Complications*, CTR. FOR REPROD. RTS. (Oct. 18, 2024), https://reproductiverights.org/blackmon-v-tennessee-abortion-ban-temporarily-blocked/.
[31] *TN Legislature Passes Bill Adding 'Clarifying Language' to State's Abortion Restrictions,* WBIR 10 NEWS, https://www.wbir.com/article/news/health/tn-house-to-debate-bill-adding-clarifying-language-states-abortion-restrictions/51-a4828a3d-a913-45c4-b443-41ac1a002907 (last updated Apr. 17, 2025).
[32] TENN. CODE ANN. § 39-15-213(c)(1). Though different health-related exceptions are stated in different parts of the code, the exception that applies to Tennessee's trigger ban governs providers' liability unless and until it is enjoined.
[33] *Id.* § 39-15-213(a)(5)(A).
[34] *Id.* § 39-15-213(a)(5)(B). "Inevitable abortion" is defined as "a dilation of the cervix prior to viability of the pregnancy, either by preterm labor or cervical insufficiency." *Id.* § 39-15-213(a)(3).

[35] *Id.* § 39-15-213(a)(5)(C).
[36] *Id.* § 39-15-213(c)(2).
[37] TENN. CODE ANN. § 39-15-209(c) (providing that the prohibition does not apply "to a partial-birth abortion that is necessary to save the life of the mother whose life is endangered by a physical disorder, illness or injury").
[38] *Id.* § 39-15-202(d)–(f) (excepting abortions provided in medical emergencies from the counseling and delay requirements and defining "medical emergency" as a condition that, "on the basis of the physician's good faith medical judgment, so complicates a medical condition of a pregnant woman as to necessitate an immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function").
[39] *Id.* § 37-10-305 (providing that a provider is not obligated to obtain consent of the young person's parent or guardian "when, in the best medical judgment of the physician . . . a medical emergency exists that so complicates the pregnancy as to require an immediate abortion").
[40] *Compare id.* § 39-15-209(c), *with id.* § 39-15-213(c)(1)(A).
[41] *Compare id.* § 39-15-202(d)-(e), (f), *with id.* § 39-15-213(c)(1)(A).
[42] *Compare id.* § 37-10-305, *with id.* § 39-15-213(c)(1)(A).
[43] *Allyson Phillips et al. v. State of Tennessee et al.*, No. 23-1196-I (Tenn. Ch. Ct., Davidson Cnty. Filed Sept. 11, 2023). *See also* Anita Wadhwani, *Signaling Skepticism That Exceptions to TN Abortion Ban Are Adequate, Judges Rule Against State,* TENNESSEE LOOKOUT, (Oct. 22, 2025), https://tennesseelookout.com/2025/10/22/signaling-skepticism-that-exceptions-to-tn-abortion-ban-are-adequate-judges-rule-against-state/.
[44] EMTALA, 42 U.S.C. § 1395dd(a).
[45] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[46] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[47] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[48] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[49] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[50] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[51] EMTALA, 42 U.S.C. § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[52] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[53] For example, in 2022, the Biden Administration issued guidance reiterating past administrative statements that the treatment required by EMTALA includes abortion care when such care is necessary to stabilize a pregnant person's emergency medical condition. Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022) ("2022 EMTALA Guidance"). While this guidance has since been rescinded, the requirements of EMTALA as outlined in it and other prior HHS statements have not changed. Indeed, in the Trump Administration's June 3, 2025 statement rescinding the 2022 guidance, the Administration stated that "CMS will continue to enforce EMTALA . . . including for identified emergency medical conditions that place the health of a pregnant woman or unborn child in serious jeopardy." Ctrs. for Medicare & Medicaid Servs., *CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA)* (June 3, 2025); *see also* Letter from Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., to Healthcare Providers (June 13, 2025) ("Kennedy Letter"), available at https://essentialhospitals.org/wp-content/uploads/2025/06/6.13.25-EMTALA-letter-final.pdf.pdf.
[54] Kennedy Letter.
[55] Kennedy Letter.
[56] *Hearing on the Fiscal Year 2026 Dep't of Health and Hum. Servs. Budget Before the H. Comm. on Energy & Com., Subcomm. on Health,* 119th Cong. (2025) (statement of Robert F. Kennedy Jr., Sec'y of Health & Hum. Serv.).
[57] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated Nov. 24, 2025).
[58] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).

[59] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[60] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[61] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[62] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025)
[63] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[64] *Texas v. Becerra*, 89 F.4th 529, 546 (5th Cir. 2024) (affirming permanent injunction barring HHS from enforcing the 2022 EMTALA Guidance's "interpretation that Texas abortion laws are preempted by EMTALA" and "it's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against [plaintiff organizations'] members."); *see also* Ctrs. for Medicare & Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act (last modified Dec. 6, 2024).
[65] A separate challenge to the guidance was filed by the Catholic Medical Association in Tennessee, Compl., *Catholic Med. Ass'n v. Dep't of Health & Hum. Servs.*, No 3:25-cv-00048, ECF No. 1 (M.D. Tenn. Jan. 10, 2025), but the plaintiff voluntarily dismissed that action on June 3, 2025.
[66] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[67] 42 U.S.C. § 300a-7(c) (2000); *Know Your Rights: Existing Laws May Protect Health Care Professionals Who Provide or Support Abortion From Discrimination in Employment*, NAT'L WOMEN'S L. CTR. (Feb. 9, 2023), https://nwlc.org/resource/know-your-rights-existing-laws-may-protect-health-care-professionals-who-provide-or-support-abortion-from-discrimination-in-employment/.
[68] TENN. CODE ANN. § 29-26-101, *et seq.*
[69] *Abortion Training and Education in a Post-*Dobbs *Landscape*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Feb. 6, 2025), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/abortion-training-and-education-in-a-post-dobbs-landscape#:~:text=Since%201996%2C%20the%20Accreditation%20Council,ob%2Dgyn%20residency%20programs13 ("Since 1996, the Accreditation Council for Graduate Medical Education (ACGME) has required integrated opt-out abortion training as a routine experience for ob-gyn residency programs."). Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).
[70] 42 U.S.C. § 238n.
[71] 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.
[72] TENN. CODE ANN. § 39-15-213(c) (stating requirements of legal abortions under Tennessee's abortion ban).
[73] *Id.* § 39-15-203(a).
[74] *Id.* § 39-15-213(a)(1) (defining abortion to exclude terminations of "ectopic or molar pregnanc[ies]").
[75] *Id.* § 39-15-203(a).
[76] *Id.*
[77] *Id.* § 68-3-505(a).
[78] *Id.* § 68-3-505(a); *id.* § 39-15-203(b)(2).
[79] *Id.* § 39-15-203(e).
[80] *Id.* § 39-15-210(b)(1).
[81] *Id.*
[82] *Id.*
[83] 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.
[84] *Id.* § 68-1-140.
[85] *Id.* § 68-3-504(a)(1).
[86] *Id.*

[87] *Id.* § 68-3-504(a)(2).
[88] *Id.* § 68-3-504(a)(3).
[89] *Id.* § 68-3-504(c).
[90] 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).
[91] 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.
[92] 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.
[93] 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.
[94] 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.
[95] TENN. CODE. ANN. § 39-15-204.
[96] TENN. CODE ANN. § 39-15-201(a), (c).
[97] *Id.* § 39-15-201(b).
[98] *Welty v. Dunaway*, 791 F.Supp.3d 818 (M.D. Tenn. 2025), appeal docketed, Nos. 25-05738 & 25-05739.
[99] TENN. CODE. ANN. § 39-15-218(a)(2).
[100] *See id.* § 39-15-213(f) (stating that § 39-15-218 is superseded).
[101] *Id.* § 63-6-1101, *et seq*.
[102] *Id.* § 63-6-1103, § 63-6-1104.

[103] *Id.* § 63-6-1108.
[104] *Id.* § 39-15-219(a). Because this section of Tennessee's code was superseded by the state's trigger ban—which restricts abortion provision to hospitals or ambulatory surgical treatment centers—the other locations mentioned in § 39-15-219(a) are likely no longer relevant.
[105] *Id.* § 39-15-219(b).
[106] *Id.* § 39-15-219(c)(1).
[107] *Id.* § 39-15-219(d)(1).
[108] *Id.* § 39-15-219(d)(2).
[109] *Id.* § 39-15-219(h). If the patient selects a different location, they are responsible for the costs. *Id.*
[110] *Id.* § 39-15-219(a)(1)(B), (b)(1). Although Tennessee law is not explicit, the fetal disposition requirement does not appear to apply to a medication abortion where the patient passes pregnancy tissue outside the medical facility. *See, e.g.*, *id.* § 39-15-219(c)(2) (stating requirements exclusively for "surgical abortion"); *id.* § 39-15-203(a) (2023) (providing that, for the purpose of the abortion reporting form, a provider is not required to report the disposition of the fetal tissue if the abortion is a medication abortion and the "expulsion of the aborted fetus or aborted fetal tissue does not take place at the facility or clinic where the procedure took place"). Additionally, because the law defines fetal remains as an "aborted fetus or fetal tissue that results from an abortion of an unborn child[,]" it does not seem to apply to fetal tissue from a miscarriage. *Id.* § 39-15-219(a)(4). As a result, if a provider provides treatment to a patient following a self-managed abortion, they are not required to comply with the requirements related to fetal and embryonic tissue disposition.