ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

NORTH CAROLINA

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

Contraception is legal.

Providing medical care for pregnancies with no cardiac activity is legal.

Providing information about how to obtain a legal abortion in another state is legal.

Abortions are legal through 12 weeks and six days of pregnancy, and North Carolina law permits some abortions after that time under exceptions for emergency, rape or incest, and “life-limiting anomalies.”

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Definition of Abortion

North Carolina law defines "abortion" as "[t]he use or prescription of any instrument or device" (for "surgical abortion"), or "[t]he use of any medicine, drug, or other substance" (for "medical abortion"), "intentionally to terminate the pregnancy of a woman known to be pregnant other than to do any of the following: a. Increase the probability of a live birth[;] b. Preserve the life or health of the child[;] c. Remove a dead, unborn child who died as the result of (i) natural causes in utero, (ii) accidental trauma, or (iii) a criminal assault on the pregnant woman or her unborn child which causes the premature termination of the pregnancy[;] d. Remove an ectopic pregnancy."[1]

Miscarriage care is legal so long as the intention is to "[r]emove a dead, unborn child who died as the result of (i) natural causes in utero, (ii) accidental trauma, or (iii) a criminal assault on the pregnant woman or her unborn child which causes the premature termination of the pregnancy." A fetus is widely understood to be "dead" when there is no fetal cardiac activity present.

Terminating an ectopic pregnancy is legal and is explicitly excluded from the definition of abortion under North Carolina law.[2]

There is no explicit crime of self-managed abortion in North Carolina and no civil law explicitly prohibiting a person from self-managing an abortion.[3]

Abortion Bans and Restrictions

Ban on Abortion After the Twelfth Week of Pregnancy

Abortions after the twelfth week of pregnancy are not legal unless one of the exceptions is met, discussed below.[4] A physician who violates the law may face penalties including revocation or annulment of their medical license by the North Carolina Medical Board.[5] "Any other licensed health care provider who violates any provision of this Article shall be subject to discipline under their respective licensing agency or board."[6]

A provider can also be sued for providing or attempting to provide abortion in violation of North Carolina law. Either an abortion patient or "any father of an unborn child that was the subject of [such] an abortion" may bring an action for damages against the provider.[7] Any such patient, as well as any "spouse, parent, sibling, or guardian of, or a current or former licensed health care provider" of such patient, or the Attorney General, may also file a lawsuit to block the provider from performing further abortions in violation of North Carolina law.[8]

Exceptions to the Ban: Abortion After the Twelfth Week of Pregnancy

Abortions may be provided after the twelfth week of pregnancy under limited circumstances. Any abortion performed after the 12th week of pregnancy under the following exceptions must be performed in a hospital.[9]

Emergency: Emergency abortions are permitted at any time when a qualified physician determines there is a medical emergency.[10] A medical emergency is defined as a condition that requires the "immediate abortion" of pregnancy to "avert [] death" of the pregnant individual or a condition in which the delay of an abortion would create "serious risk of substantial and irreversible physical impairment of a major bodily function."[11] However, the law specifies that "no condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function."[12] The physician must "document in writing the medical indications upon which the physician relied" to perform that emergency abortion and maintain the original writing in the patient's medical records, and

the physician must provide a copy of the writing to the patient.[13]

Under the emergency exception, the 72-hour delay and "informed consent" requirements do not apply.[14] However, the physician "shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 72 hour delay will create a serious risk of substantial and irreversible impairment of a major bodily function, not including psychological or emotional conditions."[15]

Emergency Exception to Parental Consent: The requirement of parental consent for unemancipated minors, described below, also contains a medical emergency exception, which is different from the general medical emergency exception. Parental consent is waived where, "in the best medical judgment of the physician based on the facts of the case before the physician, a medical emergency exists that so complicates the pregnancy as to require an immediate abortion,"[16] or "[w]here the parents refuse to consent to a procedure, and the necessity for immediate treatment is so apparent that the delay required to obtain a court order would endanger the life or seriously worsen the physical condition of the child."[17] However, "[n]o treatment shall be administered to a child over the parent's objection as herein authorized unless the physician shall first obtain the opinion of another physician licensed to practice medicine in the State of North Carolina that such procedure is necessary to prevent immediate harm to the child."[18]

Rape or Incest: When the pregnancy is the result of rape or incest, an abortion may be performed through 20 weeks of pregnancy by a qualified physician licensed to practice in North Carolina.[19] The "informed consent" requirements, including the mandatory delay and biased counseling, apply to abortions provided under this exception.

"Life-limiting Anomaly": When a qualified physician determines there exists "a physical or genetic condition that (i) is defined as a life-limiting disorder by current medical evidence and (ii) is uniformly diagnosable," abortion may be performed through 24 weeks of pregnancy.[20]

In addition to the "informed consent" mentioned above, an extra "consent form for abortion in the case of a life-limiting anomaly" is required by the North Carolina Department of Health and Human Services (DHHS) for abortions provided under this exception. The form requires initials and signatures from both the patient and physician.[21]

Other Bans and Restrictions on Abortion

"Surgical abortions", or procedural abortions, through the twelfth week of pregnancy must be provided by qualified physicians licensed to practice in North Carolina, in a hospital, ambulatory surgical center, or clinic certified by the state DHHS.[22] As of September 2024, any certified prescribers and certified pharmacies under Food and Drug Administration (FDA) regulations may provide drugs for medication abortions through the twelfth week of pregnancy.[23]

Abortions cannot be provided without "informed consent," which includes a mandatory delay and biased counseling, except in the case of medical emergencies.[24]

Mandatory Delay: North Carolina law requires a mandatory delay of 72 hours between a patient's first appointment for an abortion (whether surgical or medical) and when an abortion is provided.[25]

Parental Consent: To provide abortion to an unemancipated minor, a physician must obtain the consent of a custodial parent, legal guardian or custodian, parent with whom the minor is living, or a "grandparent with whom the minor has been living for at least six months immediately preceding the date of the minor's written consent." Alternatively, the minor may seek a judicial bypass to waive the parental consent requirement.[26]

Biased Counseling: At an in-person appointment 72 hours prior to a procedural abortion, a physician or qualified person must provide biased counseling, orally informing the patient of all the information contained in the "consent form and acknowledgement of risks statement" created by the North Carolina DHHS.[27] The form includes information such as medical risks and psychological effects associated with surgical abortion, "probable gestational age of the unborn child," where free ultrasound or heartbeat monitoring services are available, as well as various attestations about benefits or assistance programs, alternatives to abortion, and the patient's understanding of a procedural abortion.

North Carolina laws place nearly identical "informed consent" requirements on medication abortion and require a similar "consent form and acknowledgement of risks statement" for medication abortion.[28] Small differences between the consent forms for procedural and medication abortion include the latter's inclusion of information about Rh incompatibility and details about the process of medication abortion.[29] However, some of the requirements for medication abortion outlined in the consent form, such as the indication that a physician "will be physically present while the first abortion-inducing drug is administered," do not currently apply given the ongoing lawsuits referenced in the "Medication Abortion" section below.

The patient must sign and initial each item indicated in the appropriate consent form for "informed consent" to be valid.[30] For a minor (unemancipated) receiving an abortion, the minor *and* a parent with custody, a legal guardian or custodian, a parent living with the minor, or a grandparent living with the minor for at least six months immediately prior to the written consent request, must sign the consent form.[31] The physician must also sign the respective consent form, as well as a physician declaration form provided by the North Carolina DHHS.[32]

Reason Ban: A medical provider may not perform an abortion at any stage during pregnancy if they know that the patient is "seeking the abortion, in whole or in part" because of "actual or presumed race," sex, or "presence or presumed presence of Down syndrome."[33] However, there is no "affirmative duty on a physician to inquire as to whether the sex . . . is a significant factor in the pregnant woman seeking the abortion."[34]

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.[35] 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."[36] 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."[37]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[38] including people in labor or with emergency pregnancy complications,[39] unless the individual refuses to consent to such treatment.[40] 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."[41] 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.[42] 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."[43]

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.[44]

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."[45] 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."[46] 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."[47] 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.[48]

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.[49] 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]."[50] 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.[51] 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.[52] Following the change of presidential administrations, the United States dismissed that case entirely.[53]

And, in October 2024, the U.S. Supreme Court refused to review a Fifth Circuit decision blocking federal enforcement of EMTALA in certain circumstances in Texas and against other organizational plaintiffs in that case.[54] As a result, the Fifth Circuit's decision is final.[55] [56]

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.[57]

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.[58]

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.[59]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[60] 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.[61]

Documentation & Reporting

Continuous Reporting: State law requires reporting of all abortions to North Carolina DHHS through a form provided by the North Carolina DHHS.[62] North Carolina requires submission within 15 days of the last patient encounter, or by the end of the month of the last scheduled appointment, whichever is later. For abortions provided to minors, reports must be submitted within 30 days of the abortion to the North Carolina DHHS *and* Division of Social Service.[63]

Adverse events due to surgical abortion must be reported within 15 days of the end of the month in which the adverse event or complication occurred., and adverse events due to medication abortion must be reported within 3 days of the adverse event. All adverse reports can be made through a form provided by the North Carolina DHHS.[64]

As of July 2024, non-fatal adverse events due to medication abortion *do not* need to be reported to the FDA.[65]

Annual Reporting: For abortions provided after the twelfth week of pregnancy under the emergency, life-limiting anomaly, or rape or incest exceptions, the physician must document: "(i) the method used by the qualified physician to determine the probable gestational age of the unborn child at the time the procedure is to be performed, (ii) the results of the methodology, including the measurements of the unborn child, and (iii) an ultrasound image of the unborn child that depicts the measurements."[66] The physician must also document "the findings and analysis on which the qualified physician based the determination that there existed a medical emergency, life-limiting anomaly, rape or incest." These "findings and analysis" should be documented without identifying information and in a manner compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[67] On an annual basis, hospitals, ambulatory surgical facilities, and licensed clinics must provide the above documentation to the North Carolina DHHS in "statistical summary reports

concerning the medical and demographic characteristics of the abortions."[68]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions. Hospital and other healthcare systems often use their EMR's default settings that widely share patient records.[69] Though these settings are often helpful for continuity of care, they may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[70, 71]

EMRs have settings that can limit sharing of certain records and/or allow patients to choose how and when their records are shared, but because these are not the default settings, healthcare systems often must take steps to implement them.[72] For example, one EMR, Epic, has a filter that each Epic healthcare system can choose to turn on that exclusively blocks abortion care information from patients' externally-shared medical records, while allowing each patient's other medical records to be transmitted in full, in line with their authorization. We encourage you to discuss with your institution's general counsel and/or compliance or technology officers counsel alternative settings such as this that can protect abortion patient information while also complying with any other legal requirements.[73]

Counseling & Referral

Speech about abortion is legal in North Carolina and every other state. No state has an explicit abortion "gag rule" and no prosecutor has yet tried to use existing laws to impose one. Idaho is the only state where a state official has suggested otherwise.[74] Medical professionals in North Carolina can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal. Additionally, the North Carolina Attorney General, along with several District Attorneys, represented to a federal court that "none of the provisions" in the state's abortion laws make it illegal to "advis[e], procur[e], caus[e], or otherwise assist[] someone in obtaining a lawful out-of-state abortion."[75] The federal court in that case agreed that it was proper to interpret North Carolina's abortion laws in that way.[76]

Medication Abortion[77]

A federal district court ruled in April 2024 that the FDA's regulatory scheme blocks the enforcement of some (but not all) state law provisions that imposed more stringent restrictions on medication abortion because they frustrate the "purpose in creating a comprehensive federal regulatory scheme for higher-risk drugs run by the FDA."[78] The court accordingly blocked the provisions of North Carolina law that "require physician-only prescribing, in-person prescribing, dispensing, and administering, the scheduling of an in-person follow-up appointment, and non-fatal adverse event reporting to the FDA."[79] However, an appeal of this court's ruling is pending.[80] And other in-person requirements remain in place, such as the requirements for an in-person appointment 72-hours before the abortion, an ultrasound, blood type testing, and in-person examination.[81] If any "individual within the State, including a physician," "mail[s], provide[s], or suppl[ies] an abortion-inducing drug directly to a pregnant woman in violation of" these in-person requirements, they are subject to a fine of $5,000 per violation.[82]

Disposition of Fetal Tissue Remains

Fetal tissue remains are to be disposed of by burial, cremation, or incineration.[83] A hospital, medical facility, medical or research laboratory or other facility may only dispose of a "recognizable fetus," by burial or cremation.[84]

Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

References

[1] N.C. Gen. Stat §§ 90-21.81(1), (4e), (9b).
[2] N.C. Gen. Stat. §§ 90-21.81(4e)(b), (9b)(d).
[3] While there is no law explicitly criminalizing self-managed abortion in North Carolina, a teenager was arrested in August 2026 for allegedly taking abortion pills 31 weeks into her pregnancy, facing charges for assault with a deadly weapon. Her boyfriend was arrested and charged with negligent child abuse. Kylie Cheung, *North Carolina Teen Arrested for Using Abortion Pills As "Deadly Weapon,"* ABORTION, EVERY DAY (August 6, 2026), https://jessica.substack.com/p/north-carolina-teen-abortion-pill. Any individual facing prosecution or investigation because of a pregnancy outcome, including an accusation that they engaged in self-managed abortion in violation of the law, can contact If/When/How's Repro Legal Helpline at www.reprolegalhelpline.org to speak to a lawyer.
[4] N.C. Gen. Stat. § 90-21.81A(a).
[5] N.C. Gen. Stat. § 90-14(a)(2).
[6] *Id.*
[7] N.C. Gen. Stat. § 90-21.88(a).
[8] N.C. Gen. § 90-21.88(b).
[9] N.C. Gen. Stat. § 90-21.82A(c); *Planned Parenthood S. Atl. v. Stein*, No. 1:23-CV-480, 2024 WL 3551906, at *11-13 (M.D.N.C. July 26, 2024) (upholding the state's hospitalization after 12 weeks requirement). *Planned Parenthood South Atlantic. v. Stein* is a recent case, as of July 29, 2024, that revoked a preliminary injunction of and reinstated the North Carolina statute requiring that surgical abortions after 12 weeks only be performed in hospitals. N.C. Gen. Stat. § 90-21.82A(c). In the same case, the judge permanently enjoined the provision requiring physicians to document the existence or probable existence of an intrauterine pregnancy—the "IUP provision"—before performing a medical abortion. *Planned Parenthood S. Atl. v. Stein*, No. 1:23-CV-480, 2024 WL 3551906, at *31-32 (M.D.N.C. July 26, 2024). No additional filings have been made as of September 9, 2024.
[10] N.C. Gen. Stat. § 90-21.81B(1).
[11] N.C. Gen. Stat. § 90-21.81(5).
[12] N.C. Gen. Stat. § 90-21.81(5).
[13] N.C. Gen. Stat. § 90-21.86
[14] N.C. Gen. Stat. §§ 90-21.82(b), 90-21.83A(b), 90-21.85(a).

[15] N.C. Gen. Stat. § 90-21.86.
[16] N.C. Gen. Stat. § 90-21.9.
[17] N.C. Gen. Stat. § 90-21.1(4).
[18] *Id.*
[19] N.C. Gen. Stat. § 90-21.81B(3).
[20] N.C. Gen. Stat. §§ 90-21.81(4d), 90-21.81B(4).
[21] N.C. Gen. Stat. § 90-21.81D.
[22] N.C. Gen. Stat. § 90-21.81B(2).
[23] *Bryant v. Stein*, No. 1:23-CV-77, 2024 WL 1886907, at *21 (M.D.N.C. Apr. 30, 2024), *judgment entered*, No. 1:23-CV-77, 2024 WL 3107568 (M.D.N.C. June 3, 2024), *appeal docketed*, No. 24-1576(L) (4th Cir. Jun, 24, 2024).
[24] N.C. Gen. Stat. § 90-21.82(a); N.C. Gen. Stat. § 90-21.83A.
[25] N.C. Gen. Stat § 90-21.82(b)(1); N.C. Gen. Stat. § 90-21.83A(b)(1).
[26] N.C. Gen. Stat. §§ 90-21.7(a).
[27] N.C. Gen. Stat. §§ 90-21.82(b)(1)-(2).
[28] N.C. Gen. Stat. § 90-21.83A.
[29] *See* N.C. Gen. Stat. §§ 90-21.83A(b)(2).
[30] N.C. Gen. Stat. §§ 90-21.82(b)(1b)-(2); N.C. Gen. Stat. §§ 90-21.83A(b)(3)-(4).
[31] N.C. Gen. Stat. §§ 90-21.7(a), 90-21.87.
[32] N.C. Gen. Stat. § 90-21.82(b)(5).; N.C. Gen. Stat. § 90-21.83A(b)(5).
[33] N.C. Gen. Stat. § 90-21.121(a).
[34] N.C. Gen. Stat. Ann. § 90-21.121(b).
[35] EMTALA, 42 U.S.C. § 1395dd(a).
[36] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[37] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[38] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[39] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[40] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[41] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[42] 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).
[43] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[44] 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.
[45] Kennedy Letter.
[46] Kennedy Letter.
[47] *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.).
[48] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
[49] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[50] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).

[51] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[52] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[53] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[54] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[55] *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).
[56] 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.
[57] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[58] 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/.
[59] N.C. Gen. Stat. Ann. § 90-21.12 (To establish medical malpractice, a plaintiff must show that a defendant health care provider's care "was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities under the same or similar circumstances at the time of the alleged act." The plaintiff must make this showing by "the greater weight of the evidence," or, if the care was provided in an emergency, by "clear and convincing evidence.").
[60] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).
[61] 42 U.S.C. § 238n.
[62] N.C. Gen. Stat. § 90-21.93.
[63] N.C. Gen. Stat. § 90-21.93(a).
[64] N.C. Gen. Stat. §§ 90-21.93(c)-(d).
[65] *Bryant v. Stein*, No. 1:23-CV-77 (M.D.N.C. Apr. 30, 2024), *appeal docketed*, No. 24-1576(L) (4th Cir. Jun, 24, 2024).
[66] N.C. Gen. Stat. § 9021.81C(a).
[67] N.C. Gen. Stat. § 9021.81C(b).
[68] N.C. Gen. Stat. § 9021.81C(c).
[69] For example, an EMR may employ a tool that securely shares information among healthcare institutions that use the same EMR (e.g., from one hospital system to another) and allows robust sharing among affiliated healthcare institutions (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same health system).
[70] For example, if a patient travels from a ban state to an access state for abortion care or obtains an abortion in the ban state under an exception, then later obtains any type of healthcare at a different provider that uses the same EMR, the patient's records may be automatically shared with the second provider. If the second provider believes that the care violated the state's abortion ban, they may report it to authorities.
[71] Some states have taken steps to address vulnerabilities in information sharing, specifically for abortion and gender-affirming care. For example, Maryland and California, among other states, have enacted laws that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. *See, e.g.,* H.B. 812, 445th Leg., Reg. Sess. (Md. 2023), A.B. 352, 2023 Leg., Reg. Sess. (Cal. 2023).

While the federal government under the Biden administration created additional HIPAA protections related to the disclosure of reproductive health care records by issuing a HIPAA Reproductive Health Rule, in 2025, a federal district court vacated the rule nationwide and the requirements of the rule are no longer in effect (except for the notice of privacy practices provisions related to substance use disorder treatment records, which go into effect on February 16, 2026). HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32976 (2024) (modifying 45 C.F.R. §§

160, 164), *Purl v. U.S. Dep't of Health & Hum. Servs.*, No. 2:24-cv-228-Z (N.D. Tex. Jun 18, 2025) (vacating the majority of the rule). All HIPAA protections that were in place prior to this rule remain in place.

[72] Many of these setting options are quite broad, blocking not only a subsequent provider's access to more "sensitive" information, but also to less sensitive information that is critical to continuity of care. For this reason, many patients may not want to limit access to their records.

[73] E.g., healthcare institutions must comply with interoperability rules that penalize certain information blocking (though exceptions are available). *See* 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). *See also* Health Data, Technology, and Interoperability: Protecting Care Access, 89 Fed. Reg. 102512 (Dec. 17, 2024) (adding 45 C.F.R. § 171.206 to except information blocking practices intended to reduce potential exposure to legal action based on lawful reproductive health care provision, subject to certain conditions). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians.

[74] Letter from Raúl R. Labrador, Att'y Gen., State of Idaho, to Brent Crane, Representative, Idaho House of Representatives (Mar. 27, 2023).

[75] Joint Stipulation, *Planned Parenthood S. Atl. v. Stein*, No. 1:23-cv-00480 (M.D.N.C. June 6, 2023), ECF No. 30.

[76] *Planned Parenthood S. Atl. v. Stein*, 680 F. Supp. 3d 595, 598 (M.D.N.C. 2023).

[77] North Carolina law names medication abortion as "medical abortion."

[78] *Bryant v. Stein*, No. 1:23-CV-77, 2024 WL 1886907, at *21 (M.D.N.C. Apr. 30, 2024) (holding that FDA regulations preempt state physician-only requirement, in-person prescription, dispensation, administering, and follow-up requirement, and non-fatal adverse event reporting requirement to the FDA; but that FDA regulations do not preempt state requirements for in-person appointment followed by 72-hour mandatory delay, ultrasound, in-person examination, blood type testing, and non-fatal adverse event reporting to the state), *judgment entered*, No. 1:23-CV-77, 2024 WL 3107568 (M.D.N.C. June 3, 2024), *appeal docketed*, No. 24-1576(L) (4th Cir. Jun, 20, 2024). As of February 2025, the Fourth Circuit has temporarily suspended proceedings in *Bryant* until it issues a decision in a similar matter pending before the Court, *GenBioPro, Inc. v. Raynes,* No-23-2194 (4th Cir. filed Nov. 15, 2023).

[79] *Id.*

[80] *See* No.24-1576(L) (4th Cir. July 7, 2024).

[81] *Bryant*, 2024 WL 1886907, at *21.

[82] N.C. Gen. Stat. § 14-44.1(a)(1), (b).

[83] N.C. Gen. Stat. § 130A-131.10(a).

[84] N.C. Gen. Stat. § 130A-131.10(b).