

Code of Virginia

Title 32.1. Health

Subtitle .

Chapter 2. Disease Prevention and Control

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Article 1. Reporting of Diseases.

§ 32.1-35. List and reports of diseases and dangerous microbes and pathogens.

The Board shall promulgate from time to time a list of diseases, including diseases caused by exposure to any toxic substance as defined in § [32.1-239](#) and including diseases that may be caused by exposure to an agent or substance that has the potential for use as a weapon, that shall be required to be reported. The Board shall also promulgate from time to time a list of dangerous microbes and pathogens that shall be required to be reported by laboratories. The Board may classify such diseases, microbes and pathogens and prescribe the manner and time of such reporting.

Code 1950, § 32-16; 1979, c. 711; 2002, cc. [100](#), [768](#).

§ 32.1-35.1. Information on health care-associated infections.

Health care facilities that are required to report information about health care-associated infections to the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) pursuant to the Centers for Medicare and Medicaid Services reporting requirements shall release such data to the Board through the NHSN.

2005, c. [444](#); 2019, c. [293](#).

§ 32.1-36. Reports by physicians and laboratory directors.

A. Every physician practicing in this Commonwealth who shall diagnose or reasonably suspect that a patient of his has any disease required by the Board to be reported and every director of any laboratory doing business in this Commonwealth that performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by regulations of the Board. Any such report involving a disease that such physician or laboratory director has reason to believe may be caused by exposure to an agent or substance that has been or may be used as a weapon shall be reported directly to the Commissioner or his designee using an emergency response system maintained by the Department and operated twenty-four hours a day.

B. Any physician who diagnoses a venereal disease in a child twelve years of age or under shall, in addition to the requirements of subsection A hereof, report the matter, in accordance with the provisions of § [63.2-1509](#), unless the physician reasonably believes that the infection was acquired congenitally or by a means other than sexual abuse.

C. Any physician practicing in this Commonwealth shall report to the local health department the identity of any patient of his who has tested positive for exposure to human immunodeficiency virus as demonstrated by such test or tests as are approved by the Board for this purpose. However, there is no duty on the part of the physician to notify any third party other than the local health department of such test result, and a cause of action shall not arise from any failure to notify any other third party.

D. Upon investigation by the local health department of a patient reported pursuant to subsection A, the Commissioner may, to the extent permitted by law, disclose the patient's identity and disease to the patient's employer if the Commissioner determines that (i) the patient's employment responsibilities require contact with the public and (ii) the nature of the patient's disease and nature of contact with the public constitutes a threat to the public health.

The patient's identity and disease state shall be confidential as provided in §§ [32.1-36.1](#) and [32.1-41](#). Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of § [32.1-27](#).

E. Physicians and laboratory directors may voluntarily report additional information at the request of the Department of Health for special surveillance or other epidemiological studies.

F. 1. Every laboratory located in this Commonwealth shall file a written report with the Department of its inventory of dangerous microbes and pathogens on an annual basis. The laboratory shall supplement this report upon any change in such inventory as prescribed by the Board or immediately if any microbes or pathogens cannot be accounted for within twenty-four hours.

2. Except as provided in this subsection, a report submitted pursuant to this subsection shall be confidential and shall not be a public record pursuant to the Freedom of Information Act (§ [2.2-3700](#) et seq.). The Department shall cooperate with and may share information submitted to it pursuant to this subsection with the United States Centers for Disease Control and Prevention, and state and federal law enforcement agencies in any investigation involving the release, theft or loss of a dangerous microbe or pathogen required to be reported under this subsection.

3. Any unauthorized disclosure of reports made pursuant to this subsection shall be subject to the penalties of § [32.1-27](#).

Code 1950, § 32-48; 1976, c. 628; 1979, c. 711; 1981, c. 282; 1988, c. 130; 1989, c. 613; 1995, c. [534](#); 1999, c. [271](#); 2002, cc. [100](#), [768](#).

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.

A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may be released only to persons or entities permitted or authorized to obtain protected health information under any applicable federal or state law.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than \$5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or \$100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

D. This section shall not be deemed to create any duty on the part of any person who receives such test results, where none exists otherwise, to release the results to a person listed herein as authorized to receive them.

1989, c. 613; 1990, c. 777; 1993, cc. 97, 664; 2017, c. 178.

§ 32.1-37. Reports by persons other than physicians.

A. The person in charge of any medical care facility shall immediately make or cause to be made a report of a disease required by the Board to be reported when such information is available to that person and that person has reason to believe that no physician has reported such disease as provided in § 32.1-36. Such report shall be made to the local health director according to the provisions of the Board.

B. The person in charge of any residential or day program, service or facility licensed or operated by any agency of the Commonwealth, school or summer camp as defined in § 35.1-1 shall immediately make or cause to be made a report of an outbreak of disease as defined by the Board. Such report shall be made by rapid means to the local health director or to the Commissioner.

C. The person in charge of any medical care facility, residential or day program, service or facility licensed or operated by any agency of the Commonwealth, school, or summer camp as defined in § 35.1-1 may also voluntarily report additional information, including individual cases of communicable diseases, at the request of the Department of Health for special surveillance or other epidemiological studies.

Code 1950, § 32-49; 1979, c. 711; 1997, c. 271; 2008, cc. 367, 412.

§ 32.1-37.01. Posting of information about cases of communicable disease of public health threat.

A. As used in this section:

"Reporting entity" means a medical care facility, residential or day program, service or facility licensed or operated by any agency of the Commonwealth, school, or summer camp required to report an outbreak of a communicable disease pursuant to § 32.1-37.

B. Upon declaration of an emergency by the Governor pursuant to § 44-146.17 in response to a communicable disease of public health threat, the Department shall make information regarding outbreaks of such communicable disease of public health threat reported pursuant to § 32.1-37 available to the public on a website maintained by the Department, provided the release of such information does not violate the provisions of § 32.1-41. Such information shall include (i) the name of the reporting entity at which an outbreak of such communicable disease of public health threat has been reported; (ii) the number of confirmed cases of such communicable disease of public health threat reported by such reporting entity; and (iii) the number of deaths resulting from such communicable disease of public health threat reported by such reporting entity.

2020, Sp. Sess. I, cc. 12, 24.

§ 32.1-37.1. Report of diseases infecting dead human bodies.

Upon transferring custody of any dead body to any person practicing funeral services or his agent, any hospital, nursing facility or nursing home, assisted living facility, or correctional facility shall, at the time of transfer, notify the person practicing funeral services or his agent if the individual was known have had immediately prior to death an infectious disease which may be transmitted through exposure to any bodily fluids.

Any facility or members of its staff specified in this section shall not be liable for injury resulting from ordinary negligence in failing to identify, as herein prescribed, a dead body of a person known to have had an infectious disease immediately prior to death.

The Board of Health shall determine the infectious diseases for which notification is required pursuant to this section.

1988, c. 836; 1993, cc. 957, 993.

§ 32.1-37.2. Consent for testing for human immunodeficiency virus; condition on disclosure of test results; counseling required; exceptions.

A. Prior to performing any test to determine infection with human immunodeficiency virus, a medical care provider shall inform the patient that the test is planned, provide information about the test, and advise the patient that he has the right to decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.

B. Every person who has a confirmed positive test result for human immunodeficiency virus shall be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling. Appropriate counseling shall include, but not be limited to, the meaning of the test results; the need for additional testing, the etiology, prevention and effects of acquired immunodeficiency syndrome, the availability of appropriate health care, mental health care and social services, the need to notify any person who may have been exposed to the virus and the availability of assistance through the Department of Health in notifying such individuals.

C. Opportunity for face-to-face disclosure of the test results and appropriate counseling shall not be required when the tests are conducted by blood collection agencies. However, all blood collection agencies shall notify the Board of Health of any positive tests.

D. In the case of a person applying for accident and sickness or life insurance who is the subject of a test to determine infection for human immunodeficiency virus, insurers' practices including an explanation of the meaning of the test, the manner of obtaining consent, the method of disclosure of the test results and any counseling requirements shall be as set forth in the regulations of the State Corporation Commission.

1989, c. 613; 2008, c. [641](#).

§ 32.1-38. Immunity from liability.

Any person making a report or disclosure required or authorized by this chapter, including any voluntary reports submitted at the request of the Department of Health for special surveillance or other epidemiological studies, shall be immune from civil liability or criminal penalty connected therewith unless such person acted with gross negligence or malicious intent. Further, except for such reporting

requirements as may be established in this chapter or by any regulation promulgated pursuant thereto there shall be no duty on the part of any blood collection agency or tissue bank to notify any other person of any reported test results, and a cause of action shall not arise from any failure by such entity to notify others. Neither the Commissioner nor any local health director shall disclose to the public the name of any person reported or the name of any person making a report pursuant to this chapter. No person making a report required or authorized by this chapter shall be responsible for recognizing agents or suspecting the presence of any conditions beyond the competence of a reasonable person practicing his profession; however, any such person shall be immune as provided in this section when making reports in good faith without gross negligence and within the usual scope of his practice.

Code 1950, § 32-48; 1976, c. 628; 1979, c. 711; 1988, c. 130; 1990, c. 777; 1997, c. [271](#); 2002, c. [768](#).

Article 2. Investigation of Diseases.

§ 32.1-39. Surveillance and investigation.

A. The Board shall provide for the surveillance of and investigation into all preventable diseases and epidemics in this Commonwealth and into the means for the prevention of such diseases and epidemics. Surveillance and investigation may include contact tracing in accordance with the regulations of the Board. When any outbreak or unusual occurrence of a preventable disease shall be identified through reports required pursuant to Article 1 (§ [32.1-35](#) et seq.) of this chapter, the Commissioner or his designee shall investigate the disease in cooperation with the local health director or directors in the area of the disease. If in the judgment of the Commissioner the resources of the locality are insufficient to provide for adequate investigation, he may assume direct responsibility and exclusive control of the investigation, applying such resources as he may have at his disposal. The Board may issue emergency regulations and orders to accomplish the investigation.

B. When an investigation of any outbreak or occurrence of a disease identified through reports required pursuant to Article 1 (§ [32.1-35](#) et seq.) of this chapter indicates the reasonable possibility that the outbreak or occurrence was the result of exposure to an agent or substance used as a weapon, the Commissioner or his designee shall immediately report such finding to the Department of State Police for investigation. Reports, records, materials or other data reported to the Department of State Police pursuant to this section shall remain confidential and shall not be subject to the provisions of the Virginia Freedom of Information Act (§ [2.2-3700](#) et seq.). The Department of State Police, and any local law enforcement official, may release all or part of any report made or other information obtained pursuant to this section (i) where the release of such report or information may assist in the prevention of imminent harm to public health or safety, or (ii) where the release of such report or information, with patient identifying information removed, may be useful for education of the public on health, safety or homeland defense issues. Reports required by this section shall be maintained in the central repository established by the Department of State Police pursuant to the provisions of § [52-8.5](#). The Department of State Police shall immediately transmit the report to the local chief of police or sheriff with law-enforcement responsibilities both where the patient resides and where he sought the medical treatment that resulted in the report. In addition, the Department of State Police may transmit the report to federal and military law-enforcement authorities. The Department of State Police and local law-enforcement authorities shall immediately determine and implement the appropriate law-enforcement response to such reports, in accordance with their jurisdiction.

Code 1950, §§ 32-10, 32-42; 1979, c. 711; 1989, c. 613; 2002, c. 768.

§ 32.1-40. Authority of Commissioner to examine medical records.

Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the Commissioner or his designee to examine and review any medical records which he has in his possession or to which he has access upon request of the Commissioner or his designee in the course of an investigation, research or studies of diseases or deaths of public health importance. No such practitioner or person shall be liable in any action at law for permitting such examination and review.

Code 1950, § 32-10.1; 1960, c. 507; 1979, c. 711.

§ 32.1-41. Anonymity of patients and practitioners to be preserved in use of medical records.

The Commissioner or his designee shall preserve the anonymity of each patient and practitioner of the healing arts whose records are examined pursuant to § 32.1-40 except that the Commissioner, in his discretion, may divulge the identity of such patients and practitioners if pertinent to an investigation, research or study. Any person to whom such identities are divulged shall preserve their anonymity.

Code 1950, §§ 32-10.2, 32-10.3; 1960, c. 507; 1979, c. 711.

Article 3. Disease Control Measures.

§ 32.1-42. Emergency rules and regulations.

The Board of Health may promulgate regulations and orders to meet any emergency or to prevent a potential emergency caused by a disease dangerous to public health, including, but not limited to, procedures specifically responding to any disease listed pursuant to § 32.1-35 that is determined to be caused by an agent or substance used as a weapon or any communicable disease of public health threat that is involved in an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.01 et seq.) of this chapter.

1979, c. 711; 2002, c. 768; 2004, cc. 773, 1021.

§ 32.1-42.1. Administration and dispensing of necessary drugs, devices and vaccines during a declared disaster or emergency.

A. The Commissioner, pursuant to § 54.1-3408, may authorize persons who are not authorized by law to administer or dispense drugs or devices to administer or dispense all necessary drugs or devices in accordance with protocols established by the Commissioner when (i) the Governor has declared a disaster or a state of emergency, the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency, or the Board has made an emergency order pursuant to § 32.1-13 for the purpose of suppressing nuisances dangerous to the public health and communicable, contagious, and infectious diseases and other dangers to the public life and health and for the limited purpose of administering vaccines as an approved countermeasure for such communicable, contagious, and infectious diseases; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the Commissioner. For purposes of this section, "administer," "device," "dispense," and "drug" shall have the same meaning as provided in § 54.1-3401. The Commissioner shall develop protocols, in

consultation with the Department of Health Professions, that address the required training of such persons and procedures for such persons to use in administering or dispensing drugs or devices.

B. Where the Commissioner, pursuant to subsection A, authorizes persons who are not otherwise authorized by law to administer vaccines, such persons shall include any of the following who, due to their education and training, are qualified to administer drugs: (i) any person licensed by a health regulatory board within the Department of Health Professions whose license is in good standing, or was in good standing within the 20 years immediately prior to lapsing; (ii) any emergency medical services provider licensed or certified by the Department whose license or certification is in good standing, or was in good standing within the 20 years immediately prior to lapsing; and (iii) any health professions student enrolled in an accredited program in the Commonwealth who is in good academic standing with such student's school and provided that the school certifies that the student has been properly trained in the administration of vaccines. A health professions student who administers vaccines pursuant to this section shall be supervised by any eligible health care provider who holds a license issued by a health regulatory board within the Department of Health Professions, and the supervising health care provider shall not be required to be licensed in the same health profession for which the student is studying. A person who is licensed as an advanced practice registered nurse by the Boards of Medicine and Nursing or licensed as a physician assistant by the Board of Medicine who administers vaccines pursuant to this section may administer such vaccine without a written or electronic practice agreement. In the absence of gross negligence or willful misconduct, any such person authorized by the Commissioner or entity overseeing any such person who administers the vaccine pursuant to this section shall not be liable for (a) any actual or alleged injury or wrongful death or (b) any civil cause of action arising from any act or omission arising out of, related to, or alleged to have resulted in the contraction of or exposure to the communicable, contagious, and infectious disease or to have resulted from the administration of the vaccine.

2003, c. [794](#); 2007, cc. [699](#), [783](#); 2022, cc. [733](#), [774](#); 2023, c. [183](#).

§ 32.1-42.2. Declared emergency; priority for personal protective equipment and immunization funeral service licensees and funeral service establishment employees.

In any case in which the Board or the Commissioner has made an emergency order or regulation to meet an emergency, not provided for by general regulations, for the purpose of suppressing nuisances dangerous to the public health or a communicable, contagious, or infectious disease or other danger to the public life and health, funeral service licensees and any person employed by a funeral service establishment shall be included in any group afforded priority with regard to (i) access to personal protective equipment and (ii) administration of any vaccination against such communicable disease or public health threat during such emergency.

2021, Sp. Sess. I, c. [216](#).

§ 32.1-43. Authority of State Health Commissioner to require quarantine, etc.

The State Health Commissioner shall have the authority to require quarantine, isolation, immunization, decontamination, or treatment of any individual or group of individuals when he determines any such measure to be necessary to control the spread of any disease of public health importance and the authority to issue orders of isolation pursuant to Article 3.01 (§ [32.1-48.01](#) et seq.) of this chapter and orders of quarantine and orders of isolation under exceptional circumstances involving any

communicable disease of public health threat pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

Code 1950, § 32-8; 1979, c. 711; 1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-44. Isolated or quarantined persons.

The provisions of this chapter shall be construed to allow any isolated or quarantined person to choose his own treatment, whenever practicable and in the best interest of the health and safety of the isolated or quarantined person and the public; however, the conditions of any order of isolation issued pursuant to Article 3.01 (§ 32.1-48.01 et seq.) of this chapter involving a communicable disease of public health significance and any order of quarantine or order of isolation involving any communicable disease of public health threat pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter shall remain in effect until the person or persons subject to such order of quarantine or order of isolation shall no longer constitute a threat to other persons.

Code 1950, § 32-13; 1979, c. 711; 1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-45. Expense of treatment.

Except as specifically provided by law, the provisions of this chapter shall not be construed as relieving any individual of the expense, if any, of any treatment, including any person who is subject to an order of isolation issued pursuant to Article 3.01 (§ 32.1-48.01 et seq.) of this chapter or an order of quarantine or an order of isolation issued pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

Code 1950, § 32-56; 1973, c. 401; 1979, c. 711; 1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the direction and control of a health care provider, in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

C. For the purposes of this section, "health care provider" means any person, facility or agency licensed or certified to provide care or treatment by the Department of Health, Department of Behavioral Health

and Developmental Services, Department of Rehabilitative Services, or the Department of Social Services, any person licensed or certified by a health regulatory board within the Department of Health Professions except for the Boards of Funeral Directors and Embalmers and Veterinary Medicine or any personal care agency contracting with the Department of Medical Assistance Services.

D. "Health care provider," as defined in subsection C, shall be deemed to include any person who renders emergency care or assistance, without compensation and in good faith, at the scene of an accident, fire or any life-threatening emergency, or while en route therefrom to any hospital, medical clinic or doctor's office during the period while rendering such emergency care or assistance. The Department of Health shall provide appropriate counseling and opportunity for face-to-face disclosure of any test results to any such person.

E. Whenever any law-enforcement officer, salaried or volunteer firefighter, or salaried or volunteer emergency medical services provider is directly exposed to body fluids of a person in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the person who was exposed. If the person whose body fluids were involved in the exposure is deceased, the decedent's next of kin shall be deemed to have consented to testing of the decedent's blood for infection with human immunodeficiency virus or hepatitis B or C viruses and release of such test results to the person who was exposed.

F. Whenever a person is directly exposed to the body fluids of a law-enforcement officer, salaried or volunteer firefighter, or salaried or volunteer emergency medical services provider in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. The law-enforcement officer, salaried or volunteer firefighter, or salaried or volunteer emergency medical services provider shall also be deemed to have consented to the release of such test results to the person who was exposed.

G. For the purposes of this section, "law-enforcement officer" means a person who is both (i) engaged in his public duty at the time of such exposure and (ii) employed by any sheriff's office, any adult or youth correctional facility, or any state or local law-enforcement agency, or any agency or department under the direction and control of the Commonwealth or any local governing body that employs persons who have law-enforcement authority.

H. Whenever any school board employee is directly exposed to body fluids of any person in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the school board employee who was exposed.

I. Whenever any person is directly exposed to the body fluids of a school board employee in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the school board employee whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. The school board employee shall also be deemed to have consented to the release of such test results to the person.

J. For the purposes of this section, "school board employee" means a person who is both (i) acting in the course of employment at the time of such exposure and (ii) employed by any local school board in the Commonwealth.

K. For purposes of this section, if the person whose blood specimen is sought for testing is a minor, consent for obtaining such specimen shall be obtained from the parent, guardian, or person standing in loco parentis of such minor prior to initiating such testing. If the parent or guardian or person standing in loco parentis withholds such consent, or is not reasonably available, the person potentially exposed to the human immunodeficiency virus or hepatitis B or C viruses, or the employer of such person, may petition the juvenile and domestic relations district court in the county or city where the minor resides or resided, or, in the case of a nonresident, the county or city where the health care provider, law-enforcement agency or school board has its principal office or, in the case of a health care provider rendering emergency care pursuant to subsection D, the county or city where the exposure occurred, for an order requiring the minor to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section.

L. Except as provided in subsection K, if the person whose blood specimen is sought for testing refuses to provide such specimen, any person identified by this section who was potentially exposed to the human immunodeficiency virus or the hepatitis B or C viruses in the manner described by this section or the employer of such person, or the local attorney for the Commonwealth in the county or city in which the exposure occurred if such exposed person is a law-enforcement officer, may petition, on a form to be provided by the Office of the Executive Secretary of the Supreme Court of Virginia, the general district court of the county or city in which the person whose specimen is sought resides or resided, or, in the case of a nonresident, the county or city where the health care provider, law-enforcement agency or school board has its principal office or, in the case of a health care provider rendering emergency care pursuant to subsection D, the county or city where the exposure occurred, for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section. A hearing on such a petition shall be given precedence on the docket so as to be heard by the court within 48 hours of the filing of the petition, or, if the court is closed during such time period, such petition shall be heard on the next day that the court is in session. A copy of the petition, which shall specify the date and location of the hearing, shall be provided to the person whose specimen is sought. At any hearing before the court, the person whose specimen is sought or his counsel may appear. The court may be advised by the Commissioner or his designee prior to entering any testing order. If the general district court determines that there is probable cause to believe that a person identified by this section has been exposed in the manner prescribed by this section, the court shall issue an order requiring the person whose bodily fluids were involved in the exposure to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section. If a testing order is issued, both the petitioner and the person from whom the blood specimen

sought shall receive counseling and opportunity for face-to-face disclosure of any test results by a licensed practitioner or trained counselor.

M. Any person who is subject to a testing order may appeal the order of the general district court to the circuit court of the same jurisdiction within 10 days of receiving notice of the order. Any hearing conducted pursuant to this subsection shall be held in camera as soon as practicable. The record shall be sealed. The order of the circuit court shall be final and nonappealable.

N. No specimen obtained pursuant to this section shall be tested for any purpose other than for the purpose provided for in this section, nor shall the specimen or the results of any testing pursuant to this section be used for any purpose in any criminal matter or investigation. Any violation of this subsection shall constitute reversible error in any criminal case in which the specimen or results were used.

1989, c. 613; 1993, c. 315; 1994, cc. 230, 236; 1997, c. 869; 2003, c. 1; 2008, cc. 191, 339; 2009, cc. 96, 471, 552, 813, 840; 2015, cc. 51, 502, 503; 2019, c. 27; 2020, c. 502; 2024, c. 190.

§ 32.1-45.2. Public safety employees; testing for blood-borne pathogens; procedure available for certain citizens; definitions.

A. If, in the course of employment, an employee of a public safety agency is involved in a possible exposure prone incident, the employee shall immediately, or as soon thereafter as practicable, notify the agency of the incident in accordance with the agency's procedures for reporting workplace accidents.

B. If, after reviewing the facts of the possible exposure prone incident with the employee and after medical consultation, the agency concludes that it is reasonable to believe that an exposure prone incident may have occurred, and the person whose body fluids were involved in the exposure prone incident is deceased, the agency shall (i) immediately contact the custodian of the remains and request that a specimen of blood be preserved for testing and (ii) contact the next of kin of the decedent and inform the next of kin that the specimen will be tested for hepatitis B or C viruses and human immunodeficiency virus and the results of such testing released to the person who was exposed.

C. If, after reviewing the facts of the possible exposure prone incident with the employee and after medical consultation, the agency concludes that it is reasonable to believe that an exposure prone incident may have occurred and the person whose body fluids were involved in the exposure prone incident is alive, the agency shall request the person whose body fluids were involved to submit to testing for hepatitis B or C virus and human immunodeficiency virus as provided in § 32.1-37.2 and to authorize disclosure of the test results.

D. If a person is involved in a possible exposure prone incident involving the body fluids of an employee of a public safety agency, the person may request the agency to review the facts of the possible exposure prone incident for purposes of obtaining the employee's consent to test for hepatitis B or C virus and human immunodeficiency virus as provided in § 32.1-37.2 and to authorize disclosure of the test results. If, after reviewing the facts and after medical consultation, the agency concludes it is reasonable to believe an exposure prone incident involving the person and the employee may have occurred, (i) the agency shall request the employee whose body fluids were involved to give consent to submit to testing for hepatitis B or C virus and human immunodeficiency virus and to authorize disclosure of the test results or (ii) if the employee is deceased, the agency shall request the custodian of the remains to

preserve a specimen of blood and shall request the decedent's next of kin to provide consent, as provided in § 32.1-37.2, to such testing and to authorize disclosure of the test results.

E. If consent is refused under subsection C, the public safety agency or the employee may petition the general district court of the city or county in which the person resides or resided, or in the case of a nonresident, the city or county of the public safety agency's principal office, to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

If consent is refused under subsection D, the person involved in the possible exposure prone incident may petition the general district court of the city or county of the public safety agency's principal office to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

F. If the court finds by a preponderance of the evidence that an exposure prone incident has occurred, shall order testing for hepatitis B or C virus and human immunodeficiency virus and disclosure of the test results. The court shall be advised by the Commissioner or his designee in making this finding. The hearing shall be held in camera as soon as practicable after the petition is filed. The record shall be sealed.

G. A party may appeal an order of the general district court to the circuit court of the same jurisdiction within ten days from the date of the order. Any such appeal shall be de novo, in camera, and shall be heard as soon as possible by the circuit court. The circuit court shall be advised by the Commissioner or his designee. The record shall be sealed. The order of the circuit court shall be final and nonappealable.

H. Disclosure of any test results provided by this section shall be made to the district health director of the jurisdiction in which the petition was brought or the district in which the person or employee was tested. The district health director or his designee shall inform the parties of the test results and counsel them in accordance with subsection B of § 32.1-37.2.

I. The results of the tests shall be confidential as provided in § 32.1-36.1.

J. No person known or suspected to be positive for infection with hepatitis B or C virus or human immunodeficiency virus shall be refused services for that reason by any public safety agency personnel.

K. For the purpose of this section and for no other purpose, the term "employee" shall include: (i) any person providing assistance to a person employed by a public safety agency who is directly affected by possible exposure prone incident as a result of the specific crime or specific circumstances involved in the assistance and (ii) any victim of or witness to a crime who is directly affected by a possible exposure prone incident as a result of the specific crime.

L. This section shall not be deemed to create any duty on the part of any person where none exists otherwise, and a cause of action shall not arise from any failure to request consent or to consent to testing under this section. The remedies available under this section shall be exclusive.

M. For the purposes of this section:

"Exposure prone incident" means a direct exposure to body fluids of another person in a manner which may, according to the then current guidelines of the Centers for Disease Control and Prevention,

transmit hepatitis B or C virus or human immunodeficiency virus and which occurred during the commission of a criminal act, during the performance of emergency procedures, care or assistance, or the course of public safety or law-enforcement duties.

"Public safety agency" means any sheriff's office; any adult or youth correctional, law-enforcement, or fire safety organization; the Department of Forensic Science; or any agency or department that employs persons who have law-enforcement authority and which is under the direction and control of the Commonwealth or any local governing body.

1992, c. 711; 1994, c. 146; 1997, cc. 722, 804; 2008, c. 641; 2014, c. 275; 2020, c. 502.

§ 32.1-45.3. Repealed.

Repealed by Acts 2015, c. 301, cl. 1.

§ 32.1-45.4. Comprehensive harm reduction programs.

A. The Commissioner or his designee may authorize the director of a local department of health, or an other organization that promotes scientifically proven methods of mitigating health risks associated with drug use and other high-risk behaviors, to establish and operate local or regional comprehensive harm reduction programs that include the provision of sterile hypodermic needles and syringes and disposal of used hypodermic needles and syringes. The objectives of such programs shall be to (i) reduce the spread of HIV, viral hepatitis, and other blood-borne diseases in the Commonwealth; (ii) reduce the transmission of blood-borne diseases through needlestick injuries to law-enforcement and other emergency personnel; (iii) provide information to individuals who inject drugs regarding addiction recovery treatment services and encourage such individuals to participate in evidence-based substance use treatment programs; (iv) prevent opioid overdose deaths through distribution of naloxone or other opioid antagonists; and (v) incentivize the safe return and disposal of hypodermic needles and syringes. Comprehensive harm reduction programs established by the Commissioner pursuant to this section shall be operated by local health departments or affiliated organizations with which the Department contracts.

B. A comprehensive harm reduction program established pursuant to this section shall include (i) the disposal of used hypodermic needles and syringes; (ii) the provision of hypodermic needles and syringes and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused; (iii) reasonable and adequate security at program sites, equipment, and personnel; (iv) the provision of educational materials concerning (a) substance use disorder prevention, (b) overdose prevention, (c) the prevention of transmission of HIV, viral hepatitis, and other blood-borne diseases, (d) available mental health treatment options, including referrals for mental health treatment, and (e) available substance use disorder treatment options, which shall include options for medication assisted treatment of substance use disorder, including referrals for treatment; (v) access to overdose prevention kits that contain naloxone or other opioid antagonist approved by the U.S. Food and Drug Administration for opioid overdose reversal; (vi) individual harm reduction counseling, including individual consultations regarding appropriate mental health or substance use disorder treatment; and (vii) verification that a hypodermic needle or syringe or other injection supplies were obtained from a comprehensive harm reduction program established pursuant to this section.

C. The director of a local health department or representative of any other organization authorized to establish a comprehensive harm reduction program pursuant to this section shall notify the Department, in a manner and form specified by the Department, of his intent to establish a comprehensive harm reduction program. Such notice shall include (i) the name of the local health department or organization that will operate the comprehensive harm reduction program, (ii) a description of the geographic area and population to be served by the comprehensive harm reduction program, and (iii) a description of the methods by which the comprehensive harm reduction program will comply with the requirements of subsection B, including a written security plan that provides for the reasonable and adequate security of the comprehensive harm reduction program site, equipment, and personnel.

D. Written security plans required pursuant to clause (iii) of subsection C shall be filed annually with each local law-enforcement agency serving the jurisdiction in which the comprehensive harm reduction program is located for their consideration.

E. The provisions of §§ [18.2-250](#), [18.2-265.3](#), and [54.1-3466](#) shall not apply to a person who dispenses distributes hypodermic needles and syringes as part of a comprehensive harm reduction program established pursuant to this section.

F. The provisions of §§ [18.2-250](#), [18.2-265.3](#), and [54.1-3466](#) relating to possession of a controlled substance, drug paraphernalia, and controlled paraphernalia shall not apply to any person acting on behalf or for the benefit of a comprehensive harm reduction program when such possession is incident to the provision of services as part of a comprehensive harm reduction program established pursuant to this section.

G. The provisions of §§ [18.2-250](#), [18.2-265.3](#), and [54.1-3466](#) relating to possession of a controlled substance, drug paraphernalia, and controlled paraphernalia shall not apply to any person receiving services from a comprehensive harm reduction program established pursuant to this section, when (i) such controlled substance is a residual amount contained in a used needle, used hypodermic syringe, or used injection supplies obtained from or returned to a comprehensive harm reduction program established pursuant to this section, or (ii) such paraphernalia is obtained from a comprehensive harm reduction program established pursuant to this section, as evidenced by the verification required pursuant to clause (vii) of subsection B.

H. Every local health department or other organization operating a comprehensive harm reduction program pursuant to this section shall report annually by July 1 to the Department regarding, for the previous calendar year, (i) the number of individuals served by the comprehensive harm reduction program; (ii) the number of needles, hypodermic syringes, and other injection supplies distributed by the comprehensive harm reduction program; (iii) the number of overdose prevention kits described in clause (v) of subsection B distributed by the comprehensive harm reduction program; and (iv) the number and type of referrals to mental health or substance use disorder treatment services provided to individuals served by the comprehensive harm reduction program, including the number of individual referred to programs that provide naloxone or other opioid antagonists approved by the U.S. Food and Drug Administration for opioid overdose reversal.

I. Except in the case of a comprehensive harm reduction program established by the Commissioner, no state funds shall be used to purchase needles or hypodermic syringes distributed by a comprehensive harm reduction program established pursuant to this section.

2017, c. [183](#); 2020, c. [839](#).

§ 32.1-45.5. Opioid antagonist distribution program; reports.

A. The Department shall maintain a list of all agencies and organizations that submit requests for and receive opioid antagonists through its distribution program. At least quarterly, the Department shall submit a report to the Chairs of the House Committee on Appropriations, the House Committee on Health and Human Services, the Senate Committee on Finance and Appropriations, and the Senate Committee on Education and Health and the chair of the Virginia Opioid Abatement Authority with the following information: (i) the name of the agency or organization; (ii) the county, city, or town service area; (iii) the quantity, along with the specific formulation and dosage of opioid antagonist, requested by the agency or organization in its most recent order, and the date the request was made; and (iv) the quantity, along with the specific formulation and dosage of opioid antagonist, received by the agency or organization in response to its most recent order, and the date the request was fulfilled.

B. The Department shall develop a methodology to estimate annual opioid antagonist distribution program costs. In developing such methodology, the Department shall use available data and consider account saturation goals, community needs, local resources, and the costs of products. The Department shall submit an annual report estimating the opioid antagonist distribution program costs for the following fiscal year using such methodology to the Joint Commission on Health Care and the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by December 1 of each year.

2026, cc. [729](#), [1024](#).

§ 32.1-46. Immunization of patients against certain diseases.

A. The parent, guardian or person standing in loco parentis of each child within this Commonwealth shall cause such child to be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The required immunizations for attendance at a public or private elementary, middle, or secondary school, a child care center, a nursery school, home-based child care, a developmental center shall be those set forth in the State Board of Health Regulations for the Immunization of School Children. The Board's regulations shall at a minimum require:

1. A minimum of three properly spaced doses of hepatitis B vaccine (HepB).
2. A minimum of three or more properly spaced doses of diphtheria toxoid. One dose shall be administered on or after the fourth birthday.
3. A minimum of three or more properly spaced doses of tetanus toxoid. One dose shall be administered on or after the fourth birthday.
4. A minimum of three or more properly spaced doses of acellular pertussis vaccine. One dose shall be administered on or after the fourth birthday. A booster dose shall be administered prior to entry into t

seventh grade.

5. Two or three primary doses of Haemophilus influenzae type b (Hib) vaccine, depending on the manufacturer, for children up to 60 months of age.
6. Two properly spaced doses of live attenuated measles (rubeola) vaccine. The first dose shall be administered at age 12 months or older.
7. One dose of live attenuated rubella vaccine shall be administered at age 12 months or older.
8. One dose of live attenuated mumps vaccine shall be administered at age 12 months or older.
9. Two properly spaced doses of varicella vaccine. The first dose shall be administered at age 12 months or older.
10. Three or more properly spaced doses of oral polio vaccine (OPV) or inactivated polio vaccine (IPV). One dose shall be administered on or after the fourth birthday. A fourth dose shall be required if the three dose primary series consisted of a combination of OPV and IPV.
11. One to four doses, dependent on age at first dose, of properly spaced pneumococcal conjugate (PCV) vaccine for children up to 60 months of age.
12. Two doses of properly spaced human papillomavirus (HPV) vaccine. The first dose shall be administered before the child enters the seventh grade.
13. Two or three properly spaced doses of rotavirus vaccine, depending on the manufacturer, for children up to eight months of age.
14. Two properly spaced doses of hepatitis A vaccine (HAV). The first dose shall be administered at age 12 months or older.
15. Two properly spaced doses of meningococcal conjugate vaccine (MenACWY). The first dose shall be administered prior to entry to seventh grade. The second dose shall be administered prior to entry to twelfth grade.

The parent, guardian or person standing in loco parentis may have such child immunized by a physician, a physician assistant, an advanced practice registered nurse, a registered nurse, or a licensed practical nurse, or a pharmacist who administers pursuant to a valid prescription, or may present the child to the appropriate local health department, which shall administer the vaccines required by the State Board of Health Regulations for the Immunization of School Children without charge to the parent or person standing in loco parentis to the child if (i) the child is eligible for the Vaccines for Children Program or (ii) the child is eligible for coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title X of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), or 10 U.S.C. § 1071 et seq. (CHAMPUS). In cases in which a child is covered by a health carrier, Medicare, Medicaid, CHIP, or CHAMPUS, the Department shall seek reimbursement from the health carrier, Medicare, Medicaid, CHIP, or CHAMPUS for all allowable costs associated with the provision of the vaccine. For the purposes of this section, the Department shall be deemed a participating provider with a managed care health insurance plan as defined in § [32.1-137.1](#).

B. A physician, a physician assistant, an advanced practice registered nurse, a registered nurse, a licensed practical nurse, a pharmacist, or a local health department administering a vaccine required by this section shall provide to the person who presents the child for immunizations a certificate that shall state the diseases for which the child has been immunized, the numbers of doses given, the dates when administered and any further immunizations indicated.

C. The vaccines required by this section shall meet the standards prescribed in, and be administered in accordance with, the State Board of Health Regulations for the Immunization of School Children. The State Board of Health shall amend the State Board of Health Regulations for the Immunization of School Children as necessary from time to time to maintain conformity with evidence-based, routinely recommended vaccinations for children. The adoption of such regulations shall be exempt from the requirements of Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act (§ 2.2-4000 et seq.). However, the Department shall (i) provide a Notice of Intended Regulatory Action and (ii) provide for a 60-day public comment period prior to the Board's adoption of the regulations.

D. The provisions of this section shall not apply if:

1. The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board;

2. The parent or guardian presents a statement from a physician licensed to practice medicine in Virginia, a licensed advanced practice registered nurse, or a local health department that states that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child; or

3. Because the human papillomavirus is not communicable in a school setting, a parent or guardian, at the parent's or guardian's sole discretion, may elect for the parent's or guardian's child not to receive the human papillomavirus vaccine, after having reviewed materials describing the link between the human papillomavirus and cervical cancer approved for such use by the Board.

E. For the purpose of protecting the public health by ensuring that each child receives age-appropriate immunizations, any physician, physician assistant, advanced practice registered nurse, licensed institutional health care provider, or local or district health department, the Virginia Immunization Information System, and the Department of Health may share immunization and patient locator information without parental authorization, including, but not limited to, the month, day, and year of each administered immunization; the patient's name, address, telephone number, birth date, and social security number; and the parents' names. The immunization information; the patient's name, address, telephone number, birth date, and social security number; and the parents' names shall be confidential and shall only be shared for the purposes set out in this subsection.

F. The State Board of Health shall review this section annually and make recommendations for revision by September 1 to the Governor, the General Assembly, and the Joint Commission on Health Care.

Code 1950, § 32-57.1; 1968, c. 592; 1972, c. 558; 1979, c. 711; 1980, c. 410; 1989, c. 382; 1991, c. 133; 1992, cc. 127, 166; 1994, c. 62; 1995, cc. 729, 742; 1996, cc. 67, 533; 1999, cc. 632, 676, 738; 2000, c. 476;

2004, c. 855; 2005, cc. 643, 684; 2006, cc. 364, 396, 716; 2007, cc. 858, 922; 2011, c. 125; 2014, cc. 316, 344; 2016, c. 81; 2019, c. 222; 2020, c. 1223; 2023, c. 183; 2026, c. 917.

§ 32.1-46.01. Virginia Immunization Information System.

A. The Board of Health shall establish the Virginia Immunization Information System (VIIS), a statewide immunization registry that consolidates patient immunization histories from birth to death into a complete, accurate, and definitive record that may be made available to participating health care providers throughout Virginia, to the extent funds are appropriated by the General Assembly or otherwise made available. The purposes of VIIS shall be to (i) protect the public health of all citizens of the Commonwealth, (ii) prevent under-immunization and over-immunization of children, (iii) ensure up-to-date recommendations for immunization scheduling to health care providers and the Board, (iv) generate parental reminder and recall notices and manufacturer recalls, (v) develop immunization coverage reports, (vi) identify areas of under-immunized population, and (vii) provide, in the event of public health emergency, a mechanism for tracking the distribution and administration of immunizations, immune globulins, or other preventive medications or emergency treatments. Any health care provider, as defined in § 32.1-127.1:03, in the Commonwealth that administers immunizations shall report such patient immunization information to VIIS pursuant to this section.

B. The Board of Health shall promulgate regulations to implement the VIIS that shall address:

1. Registration of participants, including, but not limited to, a list of those health care entities that are authorized and required to participate and any forms and agreements necessary for compliance with the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services;
2. Procedures for confirming, continuing, and terminating participation and disciplining any participant for unauthorized use or disclosure of any VIIS data;
3. Procedures, timelines, and formats for reporting of immunizations by participants;
4. Procedures to provide for a secure system of data entry that may include encrypted online data entry or secure delivery of data files;
5. Procedures for incorporating the data reported on children's immunizations pursuant to subsection of § 32.1-46;
6. The patient identifying data to be reported, including, but not limited to, the patient's name, date of birth, gender, telephone number, home address, birth place, and mother's maiden name;
7. The patient immunization information to be reported, including, but not necessarily limited to, the type of immunization administered (specified by current procedural terminology (CPT) code or Health Level 7 (HL7) code); date of administration; identity of administering person; lot number; and if present, any contraindications, or religious or medical exemptions;
8. Mechanisms for entering into data-sharing agreements with other state and regional immunization registries for the exchange, on a periodic nonemergency basis and in the event of a public health emergency, of patient immunization information, after receiving, in writing, satisfactory assurances from

the preservation of confidentiality, a clear description of the data requested, specific details on the intended use of the data, and the identities of the persons with whom the data will be shared;

9. Procedures for the use of vital statistics data, including, but not necessarily limited to, the linking of birth certificates and death certificates;

10. Procedures for requesting immunization records that are in compliance with the requirements for disclosing health records set forth in § 32.1-127.1:03; such procedures shall address the approved uses for the requested data, to whom the data may be disclosed, and information on the provisions for disclosure of health records pursuant to § 32.1-127.1:03;

11. Procedures for releasing aggregate data, from which personal identifying data has been removed or redacted, to qualified persons for purposes of research, statistical analysis, and reporting; and

12. Procedures for the Commissioner of Health to access and release, as necessary, the data contained in VIIS in the event of an epidemic or an outbreak of any vaccine-preventable disease or the potential epidemic or epidemic of any disease of public health importance, public health significance, or public health threat for which a treatment or vaccine exists.

The Board's regulations shall also include any necessary definitions for the operation of VIIS; however "health care entity," "health care plan," and "health care provider" shall be as defined in subsection B of § 32.1-127.1:03.

C. The establishment and implementation of VIIS is hereby declared to be a necessary public health activity to ensure the integrity of the health care system in Virginia and to prevent serious harm and serious threats to the health and safety of individuals and the public. Pursuant to the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services, covered entities may disclose protected health information to the secure system established for VIIS without obtaining consent or authorization for such disclosure. Such protected health information shall be used exclusively for the purposes established in this section.

D. The Board and Commissioner of Health, any employees of the health department, any participant, and any person authorized to report or disclose immunization data hereunder shall be immune from civil liability in connection therewith unless such person acted with gross negligence or malicious intent.

E. This section shall not diminish the responsibility of any physician or other person to maintain accurate patient immunization data or the responsibility of any parent, guardian, or person standing in loco parentis to cause a child to be immunized in accordance with the provisions of § 32.1-46. Further, this section shall not be construed to require the immunization of any person who objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, or any person for whom administration of immunizing agents would be detrimental to his health.

F. The Commissioner may authorize linkages between VIIS and other secure electronic databases that contain health records reported to the Department of Health, subject to all state and federal privacy laws and regulations. These health records may include newborn screening results reported pursuant to § 32.1-65, newborn hearing screening results reported pursuant to § 32.1-64.1, and blood-lead level

screening results reported pursuant to § 32.1-46.1. Health care providers authorized to use VIIS may view the health records of individuals to whom the providers are providing health care services.

2005, cc. 643, 684; 2012, c. 147; 2021, Sp. Sess. I, c. 211.

§ 32.1-46.02. Administration of influenza vaccine to minors.

The Board shall, together with the Board of Nursing and by August 31, 2009, develop and issue guidelines for the administration of influenza vaccine to minors by licensed pharmacists, registered nurses, licensed practical nurses, or emergency medical services providers who hold an emergency medical technician intermediate or emergency medical technician paramedic certification issued by the Commissioner pursuant to § 54.1-3408. Such guidelines shall require the consent of the minor's parent, guardian, or person standing in loco parentis and shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention.

2009, c. 110; 2010, cc. 179, 252; 2015, cc. 502, 503.

§ 32.1-46.1. Board to establish protocol for identification of children with elevated blood-lead levels.

The Board shall promulgate regulations establishing a protocol for the identification of children at risk for elevated blood-lead levels which shall (i) require blood-lead level testing at appropriate ages and frequencies, when indicated, (ii) provide for criteria for determining low risk for elevated blood-lead levels and when such blood-lead level testing is not indicated, and (iii) require physicians to make available to parents information on the dangers of lead poisoning, along with a list of available resources, as part of regular well check visits for all children.

As deemed necessary by the Board, the protocol may also address follow-up testing for children with elevated blood-lead levels, dissemination of the protocol or other information to relevant health care professionals, appropriate information for parents, and other means of preventing lead poisoning among children. In promulgating such regulations, the Board shall consider the guidelines of the Centers for Disease Control and Prevention and may consider such other materials relating to lead poisoning prevention, testing, and treatment as it deems appropriate. The Board may also establish procedures governing how health care providers and laboratories report results to the Department of Health.

The Commissioner may authorize linkages between secure electronic data systems maintained by the Department of Health containing blood-lead level records and the Virginia Immunization Information System (VIIS) operated pursuant to § 32.1-46.01. The Commissioner may authorize health care providers authorized to view VIIS to view blood-lead level records of individuals to whom the provider is providing health care services. The records may be made available until the child reaches seven years of age, after which the records shall not be made available through a linkage to VIIS. Such linkage shall be subject to all applicable state and federal privacy laws and regulations.

2000, c. 907; 2003, c. 463; 2007, c. 691; 2012, c. 147.

§ 32.1-46.2. Certain testing or determination of low risk for elevated blood-lead levels required

In accordance with the protocol required by § 32.1-46.1 and the regulations of the Board of Health promulgated thereto, the parent, guardian or other person standing in loco parentis of each child with

the Commonwealth shall cause such child to be tested for elevated blood-lead levels or shall obtain a determination that the child is at low risk for elevated blood-lead levels.

The provisions of this section shall not apply to any child whose parent, guardian or other person having control or charge of such child shall object to such testing on the grounds that the procedure conflicts with his religious tenets or practices.

2000, c. [907](#).

§ 32.1-47. Exclusion from school of children not immunized.

Upon the identification of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in a public or private school, the Commissioner shall have the authority to require the exclusion from such school of all children who are not immunized against that disease.

1979, c. 711.

§ 32.1-47.1. Vaccination of children; plan enhancements.

The Department shall include in its vaccination plans procedures to ensure the prompt vaccination of all persons of school age in the Commonwealth, without preference regarding the manner of compliance with the compulsory school attendance law set forth in § [22.1-254](#), upon declaration of a public health emergency involving a vaccine-preventable disease and consent of the parent or guardian of the person of school age if such person is a minor or, if the person of school age is not a minor, of the person. Vaccination plans developed pursuant to this section shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention, and shall be subject to the same review and update requirements, process, and schedule as the State Emergency Operations Plan developed by the Department of Emergency Management pursuant to § [44-146.18](#).

2010, c. [73](#).

§ 32.1-48. Powers of Commissioner in epidemic.

A. Nothing in this article shall preclude the Commissioner from requiring immediate immunization of all persons in case of an epidemic of any disease of public health importance for which a vaccine exists other than a person to whose health the administration of a vaccine would be detrimental as certified in writing by a physician licensed to practice medicine in this Commonwealth.

B. In addition, the State Health Commissioner shall hold the powers conferred pursuant to Article 3.02 (§ [32.1-48.05](#) et seq.) of this chapter to issue orders of quarantine or prepare orders of isolation for a communicable disease of public health threat.

1979, c. 711; 2004, cc. [773](#), [1021](#).

Article 3.01. Isolation of Certain Persons with Communicable Diseases of Public Health Significance.

§ 32.1-48.01. Definitions.

As used in this article, unless the context requires a different meaning:

"Appropriate precautions" means those specific measures which have been demonstrated by current scientific evidence to assist in preventing transmission of a communicable disease of public health

significance. Appropriate precautions will vary according to the disease.

"At-risk behavior" means engaging in acts which a person, who has been informed that he is infected with a communicable disease of public health significance, knows may infect other persons without taking appropriate precautions to protect the health of the other persons.

"Communicable disease of public health significance" means an illness of public health significance, as determined by the State Health Commissioner, caused by a specific or suspected infectious agent that may be transmitted directly or indirectly from one individual to another.

"Communicable disease of public health significance" shall include, but may not be limited to, infection caused by human immunodeficiency viruses, blood-borne pathogens, and tubercle bacillus. The State Health Commissioner may determine that diseases caused by other pathogens constitute communicable diseases of public health significance. Further, "a communicable disease of public health significance" shall become a "communicable disease of public health threat" upon the finding of the State Health Commissioner of exceptional circumstances pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-48.02. Investigations of verified reports or medical evidence; counseling; outpatient and emergency treatment orders; custody upon emergency order; application of article.

A. Upon receiving at least two verified reports or upon receiving medical evidence that any person who is reputed to know that he is infected with a communicable disease of public health significance is engaging in at-risk behavior, the Commissioner or his designee may conduct an investigation through an examination of the records of the Department and other medical records to determine the disease status of the individual and that there is cause to believe he is engaging in at-risk behavior.

B. If the investigation indicates that the person has a communicable disease of public health significance caused by a non-airborne microorganism and that there is cause to believe he is engaging in at-risk behavior, the Commissioner or his designee may issue an order for such person to report to the local or district health department in the jurisdiction in which he resides to receive counseling on the etiology, effects and prevention of the specific disease of public health significance. The person conducting the counseling shall prepare and submit a report to the Commissioner or his designee on the counseling session or sessions in which he shall document that the person so counseled has been informed about the acts that constitute at-risk behavior, appropriate precautions, and the need to use appropriate precautions. The counselor shall also report any statements indicating the intentions or understanding of the person so counseled.

C. If the investigation, described in subsection A, indicates that the person has a communicable disease of public health significance caused by an airborne microorganism, such as tubercle bacillus, that causes serious disease and can result in death and that the person has refused or failed to adhere to a prescribed course of treatment and, despite counseling, is engaging in conduct that places uninfected persons at risk of contracting such airborne communicable disease of public health significance, the Commissioner or his designee may issue an outpatient treatment order for such person to report to the local or district health department in the jurisdiction in which he resides to receive appropriate outpatient treatment and education concerning his disease.

D. If the investigation, described in subsection A, indicates that the person has a communicable disease of public health significance caused by an airborne microorganism, such as tubercle bacillus, which causes serious disease and can result in death and, despite documented and appropriate counseling, is engaging in conduct that unreasonably places uninfected persons at risk of contracting such airborne communicable disease of public health significance, such as tuberculosis, and medical data demonstrate that he poses an imminent threat to the health of others, the Commissioner may issue an emergency order requiring such person to be taken immediately into custody and placed, for a period, not to exceed 48 hours, in the least restrictive, willing facility providing protection of the health of others and appropriate treatment to the person upon finding that at least one of the following conditions is met:

1. The person has refused or failed to report to the local health department after having been ordered to do so pursuant to subsection C, for appropriate outpatient treatment and education concerning his disease;
2. The person has a documented history of failure to adhere to a prescribed course of treatment; or
3. Documentation exists that the person has indicated that he will not comply with the prescribed treatment.

If the specified 48-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next day which is not a Saturday, Sunday, or legal holiday. During this period, the Commissioner shall proceed in accordance with § 32.1-48.03.

E. In order to implement an emergency order issued pursuant to subsection D of this section, all state and local law-enforcement officers are authorized to take custody of the subject of such emergency order immediately upon issuance of the emergency order by the Commissioner.

F. The provisions of this article shall only apply to communicable diseases of public health significance and shall not apply to communicable diseases of public health threat.

1990, c. 958; 1993, c. 705; 2001, c. 837; 2004, cc. 773, 1021.

§ 32.1-48.03. Petition for hearing; temporary detention.

A. Upon receiving a verified report or upon receiving medical evidence that any person who has been counseled pursuant to § 32.1-48.02 has continued to engage in at-risk behavior, the Commissioner or his designee may petition the general district court of the county or city in which such person resides order the person to appear before the court to determine whether isolation is necessary to protect the public health from the risk of infection with a communicable disease of public health significance.

B. If such person cannot be conveniently brought before the court, the court may issue an order of temporary detention. The officer executing the order of temporary detention shall order such person to remain confined in his home or another's residence or in some convenient and willing institution or other willing place for a period not to exceed 48 hours prior to a hearing. An electronic device may be used to enforce such detention in the person's home or another's residence. The institution or other place of temporary detention shall not include a jail or other place of confinement for persons charged with criminal offenses.

If the specified 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, such person may be detained until the next day which is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

C. Any person ordered to appear before the court pursuant to this section shall be informed of his right to be represented by counsel. The court shall provide the person with reasonable opportunity to employ counsel at his own expense, if so requested. If the person is not represented by counsel, the court shall appoint an attorney-at-law to represent him. Counsel so appointed shall be paid a fee of \$75 and his necessary expenses.

1990, c. 958; 2001, c. [837](#); 2004, cc. [773](#), [1021](#).

§ 32.1-48.04. Isolation hearing; conditions; order for isolation; right to appeal.

A. The isolation hearing shall be held within 48 hours of the execution of any temporary detention order issued or, if the 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the isolation hearing shall be the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

Prior to the hearing, the court shall fully inform the person who is infected with the communicable disease of public health significance of the basis for his detention, if any, the basis upon which he may be isolated, and the right of appeal of its decision.

B. An order for isolation in the person's home or another's residence or an institution or other place, including a jail when no other reasonable alternative is available, may be issued upon a finding by the court that the following conditions are met:

1. The person is infected with a communicable disease of public health significance.
2. The person is engaging in at-risk behavior.
3. The person has demonstrated an intentional disregard for the health of the public by engaging in behavior which has placed others at risk for infection with the communicable disease of public health significance.
4. There is no other reasonable alternative means of reducing the risk to public health.

C. Any order for isolation in the person's home or another's residence or an institution or other place shall be valid for no more than 120 days, or for a shorter period of time if the Commissioner or his designee, or the court upon petition, determines that the person no longer poses a substantial threat to the health of others. Orders for isolation in the person's home or another's residence may be enforced through the use of electronic devices. Orders for isolation may include additional requirements such as participation in counseling or education programs. The court may, upon finding that the person no longer poses a substantial threat to the health of others, issue an order solely for participation in counseling or educational programs.

D. Isolation orders shall not be renewed without affording the person all rights conferred in this article.

Any person under an isolation order pursuant to this section shall have the right to appeal such order to the circuit court in the jurisdiction in which he resides. Such appeal shall be filed within 30 days from

the date of the order. Notwithstanding the provisions of § 19.2-241 relating to the time within which the court shall set criminal cases for trial, any appeal of an isolation order shall be given priority over all other pending matters before the court, except those matters under appeal pursuant to § 37.2-821, and shall be heard as soon as possible by the court. The clerk of the court from which an appeal is taken shall immediately transmit the record to the clerk of the appellate court.

The appeal shall be heard de novo. An order continuing the isolation shall only be entered if the conditions set forth in subsection B are met at the time the appeal is heard.

If the person under an isolation order is not represented by counsel, the judge shall appoint an attorney at-law to represent him. Counsel so appointed shall be paid a fee of \$150 and his necessary expenses. The order of the court from which the appeal is taken shall be defended by the attorney for the Commonwealth.

1990, c. 958; 2001, c. 837; 2004, cc. 773, 1021.

Article 3.02. Quarantine and Isolation of Persons with Communicable Diseases of Public Health Threat.

§ 32.1-48.05. Application of article; determination of exceptional circumstances; regulations; duties of the State Health Commissioner not be delegated.

A. Upon a determination by the State Health Commissioner that exceptional circumstances exist relating to one or more persons in the Commonwealth who are known to have been exposed to or infected with or reasonably suspected to have been exposed to or infected with a communicable disease of public health threat and that such exceptional circumstances render the procedures of Article 3.01 (§ 32.1-48.01 et seq.) of this chapter to be insufficient control measures or that the individuals have failed or refused to comply voluntarily with the control measures directed by the State Health Commissioner in response to a communicable disease of public health threat, the State Health Commissioner may invoke the provisions of this article relating to quarantine and isolation.

B. The Board of Health shall promulgate regulations for the implementation of this article that shall (i) address the circumstances that are subject to the application of Article 3.01 (§ 32.1-48.01 et seq.) of this chapter and the exceptional circumstances in which this article may be invoked by the State Health Commissioner; (ii) provide procedures to assure that any quarantine or isolation is implemented in the least restrictive environment; (iii) ensure that the essential needs of persons subject to an order of isolation issued pursuant to this article shall be met, including, but not limited to, food, water, and health care, e.g., medications, therapies, testing, and durable medical equipment; (iv) provide procedures for proper notice of orders of quarantine and orders of isolation; (v) provide procedures for the State Health Commissioner to issue an emergency detention order for persons for whom he has probable cause to believe that they may fail or refuse to comply with an order of quarantine or an order of isolation; and (vi) address any other issue or procedure covered herein that the Board deems to be properly the subject of regulation.

C. The powers granted to the State Health Commissioner pursuant to this article shall not be delegated to or invoked by any local or district health department director. However, in the event the State Health Commissioner, duly appointed and confirmed pursuant to § 32.1-17, shall be unable to perform his duties pursuant to this article, any Deputy Commissioner, appointed by the State Health Commissioner,

and approved by the Board pursuant to § 32.1-22, shall be authorized to invoke the provisions of this article.

2004, cc. 773, 1021.

§ 32.1-48.06. Definitions.

As used in this article, unless the context requires a different meaning:

"Affected area" means any part or the whole of the Commonwealth, which has been identified as where persons reside, or may be located, who are known to have been exposed to or infected with or who are reasonably suspected to have been exposed to or infected with a communicable disease of public health threat. "Affected area" shall include, but not be limited to, cities, counties, towns, and subsections of such areas, public and private property, buildings, and other structures.

"Communicable disease of public health threat" means an illness of public health significance, as determined by the State Health Commissioner in accordance with regulations of the Board of Health, caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual to another and has been found to create risk of death or significant injury or impairment; this definition shall not, however, be construed to include human immunodeficiency viruses or tuberculosis, unless used as a bioterrorism weapon.

"Individual" shall include any companion animal. Further, whenever "person or persons" is used herein shall be deemed, when the context requires it, to include any individual.

"Companion animal" means, consistent with the provisions of § 3.2-6500, any domestic or feral dog, domestic or feral cat, nonhuman primate, guinea pig, hamster, rabbit not raised for human food or fiber, exotic or native animal, reptile, exotic or native bird, or any feral animal or any animal under the care, custody, or ownership of a person or any animal that is bought, sold, traded, or bartered by any person. Agricultural animals, game species, or any animals regulated under federal law as research animals shall not be considered companion animals for the purposes of this article.

"Isolation" means the physical separation, including confinement or restriction of movement, of an individual or individuals who are infected with or are reasonably suspected to be infected with a communicable disease of public health threat in order to prevent or limit the transmission of the communicable disease of public health threat to other uninfected and unexposed individuals.

"Law-enforcement agency" means any sheriff's office, police department, adult or youth correctional officer, or other agency or department that employs persons who have law-enforcement authority that under the direction and control of the Commonwealth or any local governing body. "Law-enforcement agency" shall include, by order of the Governor, the Virginia National Guard.

"Quarantine" means the physical separation, including confinement or restriction of movement, of an individual or individuals who are present within an affected area, as defined herein, or who are known to have been exposed or may reasonably be suspected to have been exposed to a communicable disease of public health threat and who do not yet show signs or symptoms of infection with the communicable disease of public health threat in order to prevent or limit the transmission of the communicable disease of public health threat to other unexposed and uninfected individuals.

2004, cc. 773, 1021; 2007, cc. 699, 783.

§ 32.1-48.07. Conditions for invoking the provisions of this article.

A. Prior to issuing any order of quarantine or any order of isolation pursuant to this article, the State Health Commissioner shall ensure that:

1. Any quarantine or isolation is implemented in the least restrictive environment necessary to contain the communicable disease of public health threat;
2. Any quarantined persons shall be confined separately from any isolated persons, to the maximum extent practicable;
3. Upon determining that any quarantined person can be reasonably believed to have become infected with a communicable disease of public health threat, the infected person shall be promptly removed from quarantine and placed in isolation;
4. The health and disease status of any quarantined and isolated persons shall be monitored regularly to determine if such persons require continued quarantine or isolation;
5. Any quarantined or isolated persons shall be immediately released from quarantine or isolation upon a determination by the State Health Commissioner that such quarantined or isolated persons pose no risk of transmitting the communicable disease of public health threat to other persons; and
6. The site of any quarantine or isolation shall be, to the extent practicable, safely and hygienically maintained with adequate food, clothing, health care, and other essential needs made available to the persons who are subject to any order of quarantine or isolation.

B. All persons subject to an order of quarantine or an order of isolation shall comply with the order and the conditions governing their quarantine or isolation.

C. In the case of any person who has been quarantined or isolated in a location other than a medical care facility, the State Health Commissioner shall authorize health care professionals to enter the premises of quarantine or isolation. No person, other than such authorized health care professionals, shall enter the premises of quarantine or isolation, unless authorized by the State Health Commissioner. Upon determining that any person, who has entered the premises of quarantine or isolation, poses a threat to public health and safety, the State Health Commissioner may quarantine or isolate such person.

2004, cc. [773](#), [1021](#).

§ 32.1-48.08. Declaration of quarantine.

A. The State Health Commissioner may declare a quarantine of any person or persons or any affected area after he finds that the quarantine is the necessary means to contain a communicable disease of public health threat as defined in § [32.1-48.06](#) to which such person or persons or the people of an affected area have been or may have been exposed and thus may become infected.

B. The State Health Commissioner shall record his findings and any information on which he has relied in making the finding required for quarantine pursuant to subsection A. The State Health Commissioner's record of findings concerning any communicable disease of public health threat shall be confidential and shall not be disclosed in accordance with subdivision 12 of § [2.2-3705.5](#).

C. The State Health Commissioner may order the quarantined person or persons to remain in their residences, to remain in another place where they are present, or to report to a place or places designated by the State Health Commissioner for the duration of their quarantine. An electronic device may be used to enforce any such quarantine. The Commissioner's order of quarantine shall be for a duration consistent with the known incubation period for such disease or, if the incubation period is unknown, for a period anticipated as being consistent with the incubation period for other similar infectious agents.

2004, cc. [773](#), [1021](#); 2017, c. [778](#).

§ 32.1-48.09. Order of quarantine.

A. The State Health Commissioner shall, prior to placing any person or persons under quarantine, issue an order of quarantine that shall: (i) identify the communicable disease of public health threat that is reasonably believed to be involved and the reasons why exceptional circumstances apply and the quarantine is the necessary means to contain the risks of transmission of the disease; (ii) contain sufficient information to provide reasonable notice to persons who are affected by the order of quarantine that they are subject to the order; (iii) specify the means by which the quarantine is to be implemented; (iv) establish clearly the geographic parameters of the quarantine, if involving an affected area; (v) specify the duration of the quarantine; (vi) provide sufficient directions for compliance with the quarantine to enable persons subject to the order to comply; (vii) provide timely opportunities, if not readily available under the circumstances, for the person or persons who are subject to the order to notify employers, next of kin or legally authorized representatives and the attorneys of their choice of the situation; (viii) specify the penalty or penalties that may be imposed for noncompliance with the order of quarantine pursuant to § [32.1-27](#); and (ix) include a copy of § [32.1-48.010](#) to inform any person or persons subject to an order of quarantine of the right to seek judicial review of the order.

B. No affected area shall be the subject to an order of quarantine issued by the State Health Commissioner unless the Governor, pursuant to the authority vested in him pursuant to Chapter 3.2 (§ [44-146.13](#) et seq.) of Title 44, has declared a state of emergency for such affected area of the Commonwealth.

C. The order of quarantine shall be delivered to any person or persons affected by the quarantine, in so far as practicable. However, if, in the opinion of the State Health Commissioner, the number of quarantined persons is too great to make delivery of copies of the order of quarantine to each person possible in a timely manner, or if the order of quarantine designates an affected area instead of a specific person or persons, the State Health Commissioner shall cause the order of quarantine to be communicated to the persons residing or located in the affected area.

D. The State Health Commissioner or his legal representative shall, as soon as practicable following the issuance of an order of quarantine, file a petition seeking an ex parte court review and confirmation of the quarantine.

E. The petition shall be filed in the circuit court for the city or county in which the person or persons resides or is located or, in the case of an affected area, in the circuit court of the affected jurisdiction or jurisdictions.

The petition shall include (i) a copy of the order of quarantine or all information contained in the State Health Commissioner's order of quarantine in some other format and (ii) a summary of the findings on which the Commissioner relied in deciding to issue the order of quarantine.

Upon receiving multiple orders of quarantine, the court may, on the motion of any party or on the court's own motion, consolidate the cases into a single proceeding for all orders when (i) there are common questions of law or fact relating to the individual claims or rights to be determined, (ii) the claims of the consolidated cases are substantially similar, and (iii) all parties to the orders will be adequately represented in the consolidation.

F. Prior to the expiration of the original order of quarantine, the Commissioner may extend the duration of the original order upon finding that such an extension is necessary. The Commissioner, or his legal representative, shall, as soon as practicable following the extension of an order of quarantine, file a petition seeking court review and confirmation of the order to extend the duration of the quarantine.

G. In reviewing the petition for review and confirmation of the order of quarantine or an extension of the order of quarantine, the court shall give due deference to the specialized expertise of the State Health Commissioner. The court shall grant the petition to confirm or extend the quarantine upon finding probable cause that quarantine was the necessary means to contain the disease of public health threat and is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

H. The State Health Commissioner may, if he reasonably believes that public disclosure of the information contained in the order of quarantine or the petition for court review and confirmation or extension of the order of quarantine will exacerbate the public health threat or compromise any current or future criminal investigation or compromise national security, file some or all of any petition relating to an order of quarantine under seal. After reviewing any information filed under seal by the State Health Commissioner, the court shall reseal the relevant materials to the extent necessary to protect public health and safety.

I. The State Health Commissioner shall ensure that the protected health information of any person or persons subject to the order of quarantine shall only be disclosed in compliance with § 32.1-127.1:03 of this title and the regulations relating to privacy of health records promulgated by the federal Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.).

J. Any law-enforcement officer, state or local health department employee, or any other person designated by a law-enforcement officer or state or local health department employee is empowered and authorized to deliver an order of quarantine.

2004, cc. 773, 1021; 2007, cc. 699, 783.

Article 3. Disease Control Measures.

§ 32.1-48.001. (For contingent effective date, see Acts 2021, Sp. Sess. I, c. 472, cl. 2) Real-time information sharing for emergency medical services agencies.

A. The Department shall develop and implement a system for sharing information regarding confirmed cases of communicable diseases of public health threat with emergency medical services agencies in real time during a declared public health emergency related to a communicable disease of public health threat, in order to protect the health and safety of emergency medical services personnel and the public. Such system shall include information about the location of confirmed cases of the communicable disease of public health threat, including the address of such location; the number of confirmed and suspected cases of the communicable disease of public health threat at each such location; any measures implemented at such location to prevent exposing others to the communicable disease of public health threat; and any other information that the Department shall deem appropriate. Such system shall be updated in real time to reflect each confirmed case of the communicable disease of public health threat.

B. During a declared public health emergency related to a communicable disease of public health threat, every local and district health department in the Commonwealth shall report information regarding confirmed and suspected cases of the communicable disease of public health threat to the Department in a format specified by the Board, for inclusion in the system developed pursuant to subsection A.

C. Information contained in the system developed pursuant to subsection A shall be made available to every emergency medical services agency in the Commonwealth and shall be used by such emergency medical services agencies for the purpose of (i) developing protocols to ensure the safety of emergency medical services personnel and the public when responding to calls for assistance at locations at which a case of the communicable disease of public health threat has been confirmed, including protocols related to appropriate staffing of the emergency medical services agency and the availability and use of appropriate equipment, including personal protective equipment, by emergency medical services personnel when responding to such calls, and (ii) during a declared public health emergency related to a communicable disease of public health threat, identifying specific locations at which a case of such communicable disease of public health threat has been confirmed for the purpose of implementing such protocols when responding to calls for assistance.

D. The Department shall make information submitted pursuant to subsection B and any other information contained in the system developed pursuant to subsection A available, upon request, to the Emergency Medical Services Advisory Board and each regional emergency medical services council, for the purpose of monitoring and improving the quality of emergency medical services in the Commonwealth.

E. The Department shall regularly consult with the Emergency Medical Services Advisory Board to identify the types of information that should be included in the system developed pursuant to subsection A and to revise reporting requirements for local and district health departments pursuant to subsection B.

F. Information contained in the system developed pursuant to subsection A shall be confidential and shall not be disclosed except in accordance with this section.

2021, Sp. Sess. I, c. [472](#).

Article 3.02. Quarantine and Isolation of Persons with Communicable Diseases of Public Health Threat.

§ 32.1-48.010. Appeal of any order of quarantine.

A. Any person or persons subject to an order of quarantine or a court-ordered extension of any such order pursuant to this article may file an appeal of the order of quarantine as such order applies to such person or persons in the circuit court for the city or county in which the subject or subjects of the order reside or are located or the circuit court for the jurisdiction or jurisdictions for any affected area. Any petition for appeal shall be in writing, shall set forth the grounds on which the order of quarantine is being challenged vis-a-vis the subject person or persons or affected area, and shall be served upon the State Health Commissioner or his legal representative.

B. A hearing on the appeal of the order of quarantine shall be held within 48 hours of the filing of the petition for appeal or, if the 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the hearing shall be held on the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

In extraordinary circumstances, for good cause shown, the Commissioner may request a continuance of the hearing, which the court shall only grant after giving due regard to the rights of the affected individuals, the protection of the public health and safety, the severity of the emergency, and the availability of witnesses and evidence.

C. Any person appealing an order of quarantine shall have the burden of proving that he is not properly the subject of the order of quarantine.

D. The filing of an appeal shall not stay any order of quarantine.

E. Upon receiving multiple appeals of an order of quarantine that applies to a group of persons or an affected area, the court may, on the motion of any party or on the court's own motion, consolidate the cases in a single proceeding for all appeals when (i) there are common questions of law or fact relating to the individual claims or rights to be determined; (ii) the claims of the consolidated cases are substantially similar; and (iii) all parties to the appeals will be adequately represented in the consolidation.

F. The circuit court shall not conduct a de novo review of the order of quarantine; however, the court shall consider the existing record and such supplemental evidence as the court shall consider relevant. The court shall conduct the hearing on an appeal of an order of quarantine in a manner that will protect the health and safety of court personnel, counsels, witnesses, and the general public and in accordance with rules of the Supreme Court of Virginia pursuant to subsection C of § 17.1-503. The court may, for good cause shown, hold all or any portion of the hearings in camera upon motion of any party or upon the court's own motion.

G. Upon completion of the hearing, the court may (i) vacate or modify the order of quarantine as such order applies to any person who filed the appeal and who is not, according to the record and the supplemental evidence, appropriately subject to the order of quarantine; (ii) vacate or modify the order of quarantine as such order applies to all persons who filed an appeal and who are not, according to the record and the supplemental evidence, appropriately subject to the order of quarantine; (iii) confirm the

order of quarantine as it applies to any person or all appealing parties upon a finding that such person or persons are appropriately subject to the order of quarantine and that quarantine is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat; or (iv) confirm the order of quarantine as it applies to all persons subject to the order upon finding that all such persons are appropriately subject to the order of quarantine and that quarantine is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

In any case in which the court shall vacate the order of quarantine as it applies to any person who has filed a request for review of such order and who is subject to such order or as it applies to all persons seeking judicial review who are subject to such order, the person or persons shall be immediately released from quarantine unless such order to vacate the quarantine shall be stayed by the filing of an appeal to the Supreme Court or the Court of Appeals. Any party to the case may file an appeal of the circuit court decisions to the Court of Appeals. Parties to the case shall include any person who is subject to an order of quarantine and has filed an appeal of such order with the circuit court and the State Health Commissioner.

H. Appeals of any final order of any circuit court regarding the State Health Commissioner's petition for review and confirmation or extension of an order of quarantine or any appeal of an order of quarantine by a person or persons who are subject to such order shall be appealable to the Court of Appeals, with expedited review in accordance with the rules of the court pursuant to subsection C of § 17.1-503.

I. Appeals of any circuit court order relating to an order of quarantine shall not stay any order of quarantine.

J. Persons requesting judicial review of any order of quarantine shall have the right to be represented by an attorney in all proceedings. If the person is unable to afford an attorney, counsel shall be appointed for the person by the circuit court for the jurisdiction in which the person or persons who are subject to the order of quarantine reside or, in the case of an affected area, by the circuit court for the jurisdiction or jurisdictions for the affected area. Counsel so appointed shall be paid at a rate established by the Supreme Court of Virginia from the Commonwealth's criminal fund.

2004, cc. 773, 1021; 2007, cc. 699, 783; 2021, Sp. Sess. I, c. 489.

§ 32.1-48.011. Isolation may be ordered under certain exceptional circumstances; Commissioner authorized to require hospitalization or other health care.

A. Whenever the State Health Commissioner makes a determination of exceptional circumstances pursuant to § 32.1-48.05 and that the isolation procedures set forth in Article 3.01 (§ 32.1-48.01 et seq. of this chapter) are insufficient control measures to contain a communicable disease of public health threat, the isolation procedures herein may be invoked.

B. The State Health Commissioner may order the isolation of a person or persons upon a finding that (i) such person or persons are infected with or may reasonably be suspected to be infected with a communicable disease of public health threat and (ii) isolation is necessary to protect the public health.

to ensure such isolated person or persons receive appropriate medical treatment, and to protect health care providers and others who may come into contact with such infected person or persons.

C. The State Health Commissioner shall record his findings and any information on which he has relied in making the finding required for isolation pursuant to this section. The State Health Commissioner's record of findings concerning any communicable disease of public health threat that is involved in an order of isolation shall be confidential and shall not be disclosed in accordance with subdivision 12 of [2.2-3705.5](#).

D. The Commissioner may order the isolated person or persons to remain in their places of residence, remain in another place where they are present, or to report to a place or facility designated by the Commissioner for the duration of their isolation. An electronic device may be used to enforce any such isolation. The Commissioner's order of isolation shall be for a duration consistent with the known course of such communicable disease of public health threat or, if the course of the disease is unknown or uncertain, for a period consistent with the probable course of the communicable disease of public health threat.

E. To the extent that persons subject to an order of isolation pursuant to this article require hospitalization or other health care services, the State Health Commissioner shall be authorized to require that such services be provided.

F. The State Health Commissioner shall also have the authority to monitor the medical condition of any person or persons subject to an order of isolation pursuant to this article through regular visits by public health nurses or such other means as the Commissioner shall determine to be necessary.

2004, cc. [773](#), [1021](#); 2017, c. [778](#).

§ 32.1-48.012. Isolation order.

A. The State Health Commissioner shall, prior to placing any person or persons in isolation, prepare a written order of isolation that shall: (i) identify the person or persons subject to such order of isolation; (ii) identify the site of isolation, which may, in the Commissioner's discretion, include the residence of any isolated individual; (iii) specify the date and time that isolation is to commence; (iv) identify the communicable disease of public health threat or the suspected communicable disease of public health threat with which the person or persons are known to be infected or reasonably suspected to be infected; (v) specify the bases for isolation, including why isolation is the necessary means to contain transmission of the disease, and any conditions of the isolation; (vi) provide timely opportunities, if not readily available under the circumstances, for the person or persons who are subject to the order to notify employers, next of kin or legally authorized representatives and the attorneys of their choice of the situation; (vii) specify the penalty or penalties that may be imposed for noncompliance with order of isolation pursuant to [§ 32.1-27](#); and (viii) include a copy of [§ 32.1-48.013](#) to inform any person or persons subject to an order of isolation of the right to seek judicial review of the order.

B. No affected area shall be the subject of an order of isolation prepared by the State Health Commissioner unless the Governor, pursuant to the authority vested in him pursuant to Chapter 3.2 ([§ 44-146.13](#) et seq.) of Title 44, has declared a state of emergency for such affected area of the Commonwealth.

C. The order of isolation shall be delivered to any person or persons affected by the isolation, in so far practicable. However, if, in the opinion of the State Health Commissioner, the number of isolated persons is too great to make delivery of copies of the order of isolation to each person possible in a timely manner, or if the order of isolation designates an affected area instead of a specific person or persons, the State Health Commissioner shall cause the order of isolation to be communicated to the persons residing or located in the affected area.

D. The State Health Commissioner shall, as soon as practicable following the issuance of an order of isolation, file a petition seeking an ex parte court order to review and confirm the isolation.

E. The petition shall be filed in the circuit court for the city or county in which the person or persons resides or is located or, in the case of an affected area, in the circuit court of the affected jurisdiction or jurisdictions.

Upon receiving multiple orders of isolation, the court may, on the motion of any party or on the court's own motion, consolidate the cases into a single proceeding for all orders when (i) there are common questions of law or fact relating to the individual claims or rights to be determined, (ii) the claims of the cases are substantially similar, and (iii) all parties to the orders will be adequately represented in the consolidation.

F. The petition shall include (i) a copy of the order of isolation or all information contained in the State Health Commissioner's order of isolation in some other format and (ii) a summary of the findings on which the Commissioner relied in determining that an order of isolation was required to contain the transmission of the communicable disease of public health threat.

G. Prior to the expiration of the original order of isolation, the Commissioner may extend the duration of the original order upon finding that such an extension is necessary. The Commissioner, or his legal representative, shall, as soon as practicable following the extension of an order of isolation, file a petition seeking court review and confirmation of the order to extend the duration of the isolation.

H. In reviewing any petition for review and confirmation or extension of the order of isolation, the court shall give due deference to the specialized expertise of the State Health Commissioner. The court shall grant the petition to confirm or extend the isolation upon finding probable cause that isolation was the necessary means and remains the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

I. The State Health Commissioner may, if he reasonably believes that public disclosure of the information contained in the order of isolation or the petition for review and confirmation or extension of the order of isolation will exacerbate the public health threat or compromise any current or future criminal investigation or compromise national security, file some or all of any petition to extend an order of isolation under seal. After reviewing any information filed under seal by the State Health Commissioner, the court shall reseal the relevant materials to the extent necessary to protect public health and safety.

J. The State Health Commissioner shall ensure that the protected health information of any person or persons subject to the order of isolation shall only be disclosed in compliance with the regulations

relating to privacy of health records promulgated by the federal Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996.

K. Any law-enforcement officer, state or local health department employee, or any other person designated by a law-enforcement officer or state or local health department employee is empowered and authorized to deliver an order of isolation.

2004, cc. [773](#), [1021](#); 2007, cc. [699](#), [783](#).

§ 32.1-48.013. Appeal of any order of isolation.

A. Any person or persons subject to an order of isolation or a court-ordered confirmation or extension of any such order pursuant to this article may file an appeal of the order of isolation in the circuit court of the city or county in which such person or persons reside or are located or, in the case of an affected area, in the circuit court for any affected jurisdiction or jurisdictions. Any petition for appeal shall be in writing, shall set forth the grounds on which the order of isolation is being challenged vis-a-vis the subject person or persons or affected area, and shall be served upon the State Health Commissioner or his legal representative.

B. A hearing on the appeal of the order of isolation shall be held within 48 hours of the filing of the petition for appeal or, if the 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the hearing shall be held on the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

In extraordinary circumstances, for good cause shown, the Commissioner may request a continuance of the hearing, which the court shall only grant after giving due regard to the rights of the affected individuals, the protection of the public health and safety, the severity of the emergency, and the availability of witnesses and evidence.

C. Any person appealing an order of isolation shall have the burden of proving that he is not properly the subject of the order of isolation.

D. An appeal shall not stay any order of isolation.

E. Upon receiving multiple appeals of an order of isolation, the court may, on the motion of any party or on the court's own motion, consolidate the cases in a single proceeding for all appeals when (i) there are common questions of law or fact relating to the individual claims or rights to be determined; (ii) the claims of the consolidated cases are substantially similar; and (iii) all parties to the appeals will be adequately represented in the consolidation.

F. The circuit court shall not conduct a de novo review of the order of isolation; however, the court shall consider the existing record and such supplemental evidence as the court shall consider relevant. The court shall conduct the hearing on an appeal of an order of isolation in a manner that will protect the health and safety of court personnel, counsels, witnesses, and the general public and in accordance with the rules of the Supreme Court of Virginia pursuant to subsection C of § [17.1-503](#). The court may, for good cause shown, hold all or any portion of the hearings in camera upon motion of any party or the court's own motion.

G. Upon completion of the hearing, the court may (i) vacate or modify the order of isolation as such order applies to any person who filed the appeal and who is not, according to the record and the supplemental evidence, appropriately subject to the order of isolation; (ii) vacate or modify the order of isolation as such order applies to all persons who filed an appeal and who are not, according to the record and the supplemental evidence, appropriately subject to the order of isolation; (iii) confirm the order of isolation as it applies to any person or all appealing parties upon a finding that such person or persons are appropriately subject to the order of isolation and that isolation is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective infection control measures and the nature of the communicable disease of public health threat; or (iv) confirm the order of isolation as it applies to all persons subject to the order upon finding that all such persons are appropriately subject to the order of isolation and that isolation is being implemented in the least restrictive environment to address the public health threat effectively given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

In any case in which the court shall vacate the order of isolation as it applies to any person who has filed a request for review of such order and who is subject to such order or as it applies to all persons seeking judicial review who are subject to such order, the person or persons shall be immediately released from isolation unless such order to vacate the isolation shall be stayed by the filing of an appeal to the Court of Appeals. Any party to the case may file an appeal of the circuit court decisions to the Court of Appeals. Parties to the case shall include any person who is subject to an order of isolation and has filed an appeal of such order with the circuit court and the State Health Commissioner.

H. Appeals of any final order of any circuit court regarding the State Health Commissioner's petition for review and confirmation or extension of an order of isolation or any appeal of an order of isolation by person or persons who are subject to such order shall be appealable to the Court of Appeals, with an expedited review in accordance with the rules of the court pursuant to subsection C of § 17.1-503.

I. Appeals of any circuit court order relating to an order of isolation shall not stay any order of isolation.

J. Persons appealing any order of isolation shall have the right to be represented by an attorney in all proceedings. If the person is unable to afford an attorney, counsel shall be appointed for the person by the circuit court for the jurisdiction in which the person or persons who are subject to the order of isolation reside or, in the case of an affected area, by the circuit court for the jurisdiction or jurisdiction for the affected area. Counsel so appointed shall be paid at a rate established by the Supreme Court of Virginia from the Commonwealth's criminal fund.

2004, cc. 773, 1021; 2007, cc. 699, 783; 2021, Sp. Sess. I, c. 489.

§ 32.1-48.013:1. Electronic filings as protection from communicable disease.

Notwithstanding Rule 1:17 of the Supreme Court of Virginia, a court in its discretion may permit the electronic or facsimile filing of a petition, notice, brief, notice of appeal, or other legal document when such filing is necessary to expedite the proceedings or to protect the public, court officials, or others participating in the proceedings from exposure to a communicable disease.

2007, cc. 699, 783.

§ 32.1-48.014. Enforcement of orders of quarantine or isolation; penalties.

A. Any person who does not comply with a validly issued order of quarantine or order of isolation issued or prepared pursuant to this article shall be subject to the penalties provided in § 32.1-27, including, upon conviction, a Class 1 misdemeanor and payment of civil penalties.

B. Any order of quarantine or isolation shall be enforced by law-enforcement agencies, as directed by the State Health Commissioner. Any enforcement authority directed to law-enforcement agencies by the Commissioner shall expressly include, but need not be limited to, the power to detain or arrest any person or persons identified as in violation of any order of quarantine or isolation, or for whom probable cause exists that he may fail or refuse to comply with any such order.

Any person or persons so detained shall be held in the least restrictive environment that can provide any required health care or other services for such person.

C. Every attorney for the Commonwealth shall have the duty to prosecute, without delay, any violation of this chapter in accordance with the penalties set forth in § 32.1-27.

D. Pursuant to 42 U.S.C. § 264 et seq. and 42 C.F.R. Parts 70 and 71, any order of quarantine or isolation issued by the Director of the Centers for Disease Control and Prevention affecting the Commonwealth or the Metropolitan Washington Airports Authority may be enforced by local law-enforcement officers or officers of the Metropolitan Washington Airports Authority with jurisdiction over the facility involved in the quarantine or isolation order.

2004, cc. 773, 1021; 2007, cc. 699, 783.

§ 32.1-48.015. Authorization to disclose health records.

A. The provisions of this article are hereby declared to be necessary to prevent serious harm and serious threats to the health and safety of individuals and the public in Virginia for purposes of authorizing the State Health Commissioner or his designee to examine and review any health records of any person or persons subject to any order of quarantine or order of isolation pursuant to this article and the regulations of the Department of Health and Human Services promulgated in compliance with the Health Insurance Portability and Accountability Act of 1996, as amended. The State Health Commissioner shall authorize any designee in writing to so examine and review any health records of any person or persons subject to any order of quarantine or order of isolation pursuant to this article.

B. Pursuant to the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services, covered entities may disclose protected health information to the State Health Commissioner or his designee without obtaining consent or authorization for such disclosure from the person who is the subject of the records. Such protected health information shall be used to facilitate the health care of any person or persons who are subject to an order of quarantine or an order of isolation. The State Health Commissioner or his designee shall only redisclose such protected health information in compliance with the aforementioned federal regulations. Further, the protected health information disclosed to the State Health Commissioner or his designee shall be held confidential and shall not be disclosed pursuant to the provisions of subdivision 12 of § 2.2-3705.5.

C. Pursuant to subsection G of § 32.1-116.3, any person requesting or requiring any employee of a public safety agency as defined in subsection M of § 32.1-45.2 to arrest, transfer, or otherwise exercise

custodial supervision over an individual known to the requesting person (i) to be infected with any communicable disease or (ii) to be subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 shall inform such employee of a public safety agency of the potential risk of exposure to a communicable disease.

2004, cc. 773, 1021; 2007, cc. 699, 783; 2017, c. 778; 2020, c. 502.

§ 32.1-48.016. Immunity from liability.

Any person, including a person who serves in a Medical Reserve Corps (MRC) unit or on a Community Emergency Response Team (CERT), who, in good faith and in the performance of his duties, acts in compliance with this article and the Board of Health's regulations shall not be liable for any civil damages for any act or omission resulting from such actions unless such act or omission was the result of gross negligence or willful misconduct.

2004, cc. 773, 1021; 2005, c. 474.

§ 32.1-48.017. Use of public or private property or facilities.

A. Upon the declaration by the Governor of a state of emergency pursuant to § 44-146.17, the State Health Commissioner, acting in concert with the Governor, shall be authorized to require the use of any public or private property, building or facility to implement any order of quarantine or order of isolation. The State Health Commissioner and the Governor shall find, together, that the use of the property, building or facility is necessary and appropriate to enforce an order of quarantine or an order of isolation in the least restrictive environment.

B. If the Commissioner and the Governor elect to use any public or private property, building or facility pursuant to this article and this section, the Commissioner shall make accommodations, in conjunction with the owner or operator of the property, building or facility, for persons who are employed in, using or occupying the property, building or facility and who are not covered by the relevant order of quarantine or order of isolation.

C. Owners or operators of any property, building or facility so commandeered shall be entitled to compensation.

2004, cc. 773, 1021.

Article 3.1. Control of Rabies.

§ 32.1-48.1. Regulation of State Health Commissioner declaring existence of rabies; display and publication.

Whenever the State Health Commissioner is informed that an outbreak of rabies has occurred in a county or city, he may, after consulting with the Commissioner of Agriculture and Consumer Services and the Executive Director of the Department of Wildlife Resources, adopt a regulation declaring the existence of rabies in such county or city and containing such requirements as are hereinafter set forth. Such regulations shall be prominently displayed throughout the county or city and shall be published therein by signs or otherwise to call the attention of the public to the existence of such outbreak.

1954, c. 339, § 29-213.1; 1987, c. 488; 2020, c. 958.

§ 32.1-48.2. Regulation of Commissioner requiring vaccination or inoculation of dogs.

When the State Health Commissioner has declared that an outbreak of rabies exists in a county or city he may adopt a regulation requiring all dogs therein to be vaccinated or inoculated against rabies, with such exceptions as he deems appropriate. Such regulation shall set forth the persons by whom and the time within which such vaccination or inoculation may be required. The State Health Commissioner may establish such clinics and furnish other services and supplies as will enable the prompt vaccination or inoculation of all dogs in such county or city.

1954, c. 339, § 29-213.2; 1987, c. 488.

§ 32.1-48.3. Regulations of Commissioner covering local ordinances and requirements.

If the governing body of the county or city in which the outbreak exists does not adopt, under § 3.2-6522, subsection A of § 3.2-6525, §§ 3.2-6538, 3.2-6539, and 3.2-6546, ordinances, regulations and measures to prohibit the running at large of dogs and to prevent the spread of rabies, the State Health Commissioner is authorized to adopt regulations providing for the matters contained in such sections and to enforce the same in the same manner as if they had been specifically adopted by the governing body of the county or city involved, and the provisions of such sections shall apply mutatis mutandis to the regulations adopted by the Commissioner hereunder.

1954, c. 339, § 29-213.3; 1987, c. 488; 2001, c. 674.

§ 32.1-48.4. Commissioner to cooperate with local governing bodies and agencies.

The Commissioner shall, insofar as practicable, cooperate with the local governing body and agencies of the county or city involved to the end that a joint program may be adopted and enforced for the reduction and elimination of rabies.

1954, c. 339, § 29-213.4; 1987, c. 488.

Article 4. Tuberculosis.

§ 32.1-49. Tuberculosis required to be reported.

The Board shall include tuberculosis in the list of diseases provided for in § 32.1-35 which are required to be reported.

1979, c. 711.

§ 32.1-49.1. Definitions.

"Active tuberculosis disease" means a communicable disease caused by an airborne microorganism and characterized by the presence of either (i) a specimen of sputum or other bodily fluid or tissue that has been found to contain tubercle bacilli as evidenced by culture or other definitive diagnostic test as established by the Commissioner, (ii) a specimen of sputum or other bodily fluid or tissue that is suspected to contain tubercle bacilli as evidenced by smear and sufficient clinical and radiographic evidence of active tuberculosis disease is present as determined by a physician licensed to practice medicine in the Commonwealth, or (iii) sufficient clinical and radiographic evidence of active tuberculosis disease as determined by the Commissioner is present, but a specimen of sputum or other bodily fluid or tissue containing or suspected to contain tubercle bacilli is unobtainable.

"Tubercle bacilli" means disease-causing organisms belonging to the *Mycobacterium tuberculosis* complex and includes *Mycobacterium tuberculosis*, *Mycobacterium bovis*, *Mycobacterium africanum* c

other members as established by the Commissioner.

"Tuberculosis" means a disease caused by tubercle bacilli.

2001, c. 459.

§ 32.1-50. Examination of persons suspected of having active tuberculosis disease; reporting; report forms; report schedule; laboratory reports and required samples.

A. Any local health director may request any person having or reasonably suspected of having active tuberculosis disease to be examined immediately for the purpose of ascertaining the presence or absence of the disease. Such examination may be made by any licensed physician or licensed advanced practice registered nurse selected by such person at his own expense and approved by the local health director or by the local health director at no cost to such person.

B. Each physician or advanced practice registered nurse practicing in the Commonwealth who diagnoses or treats a person for active tuberculosis disease, or a physician assistant who treats a person for active tuberculosis disease, as defined in § 32.1-49.1 and each person in charge of a medical care facility providing inpatient or outpatient diagnosis or treatment for active tuberculosis disease shall report to the local health director within such time period and in such manner as may be prescribed by regulations of the Board. Such report, at a minimum, shall include an initial report when there are reasonable grounds to believe that a person has active tuberculosis disease, and a subsequent report when a person ceases treatment for tuberculosis disease. Cessation of treatment may be inferred when the person (i) fails to keep a scheduled appointment, (ii) relocates without transferring care, or (iii) discontinues care either upon or against the advice of the treating physician, physician assistant, or advanced practice registered nurse.

C. The initial disease report shall include the following: the affected person's name; date of birth; gender; address; pertinent clinical, radiographic, microbiologic, and pathologic reports, whether final or pending; such other information as is needed to locate the patient for follow-up; and any other information as prescribed by regulations of the Board.

D. Subsequent reports shall be submitted within such time, at such frequency, and in such manner as may be prescribed by regulations of the Board and shall provide updated clinical status, bacteriologic and radiographic results, assessment of treatment adherence, name of current care provider, and any other information as prescribed by the Board.

E. Every director of any laboratory doing business in the Commonwealth shall, according to the manner and schedule as determined by the Board, report any result diagnostic of or highly correlated with active tuberculosis disease, whether testing is done in-house or referred to an out-of-state laboratory, including cultures positive for tubercle bacilli and smears suggestive of tubercle bacilli, and shall report the results of tests for antimicrobial susceptibility performed on cultures positive for tubercle bacilli. Each director of any laboratory shall also submit a representative and viable sample of the initial culture to the Virginia Division of Consolidated Laboratory Services or other laboratory designated by the Board to receive such specimen in order to (i) ensure testing for antimicrobial susceptibility on each initial isolate from a person with active tuberculosis disease, and (ii) establish a library of such isolates for the purpose of disease strain analysis as indicated by epidemiological investigations.

Code 1950, § 32-85.1; 1956, c. 482; 1979, c. 711; 2001, c. 459; 2004, c. 855; 2006, cc. 46, 396, 822; 2023, 183.

§ 32.1-50.1. Treatment plan; submission of plan and mediation of disagreements; determination of cure.

A. Each physician practicing in the Commonwealth who assumes responsibility for the treatment of a person for active tuberculosis as defined in this article and each person in charge of a medical care facility providing inpatient or outpatient treatment to a person with active tuberculosis shall, with the assistance and acknowledgement of that person, develop, maintain, and update as indicated, an individualized written plan of treatment tailored to the person's medical and personal needs and identifying the method for effective treatment and prevention of transmission. At a minimum, the plan shall specifically include verified patient address, name of the medical provider who has assumed responsibility for treatment, planned course of anti-tuberculosis drug therapy, estimated date of treatment completion, and means of ensuring successful completion of that treatment.

B. The written treatment plan shall upon request be submitted by the medical provider to the local health director in a manner determined by the Board and shall be subject to approval of the local health director. The Commissioner shall have the authority to settle, based on statewide standards, disagreements between the written plan so submitted and standards of care established by the local health director.

C. Each treating physician or person in charge of a medical facility providing outpatient or inpatient care to a person with active tuberculosis disease shall maintain and submit to the local health director upon his request, written documentation of that person's adherence to the treatment plan.

D. Each person in charge of a medical care facility providing inpatient treatment to a person with active tuberculosis disease and each person in charge of a state correctional or local correctional or detention facility that has in its custody a person with active tuberculosis shall submit to the local health director in the manner determined by the Board, the plan of treatment for such person as required in this article. The person in charge shall encourage the person to comply with such treatment plan; however, if such person with active tuberculosis indicates an unwillingness to comply with the treatment plan upon release, or exhibits behavior that indicates noncompliance, the person in charge, in conjunction with the local health director, may request the Commissioner to issue an emergency order requiring such person to be taken into custody pursuant to § 32.1-48.02 or other detention or custody options available pursuant to § 32.1-48.03 or § 32.1-48.04.

E. Once established in a person, active tuberculosis disease shall be considered present until (i) the person has received a complete and adequate course of antituberculosis drug therapy as established by the Commissioner in accordance with guidelines developed by the American Thoracic Society and Centers for Disease Control and Prevention and (ii) three successive cultures of specimens of sputum or other bodily fluid or tissue collected at intervals of no less than one week, or other definitive diagnostic test as established by the Commissioner demonstrate no viable tubercle bacilli, or the Commissioner or his designee determines that the clinical, laboratory, or radiographic evidence leads to a diagnosis other than active tuberculosis disease.

2001, c. 459.

§ 32.1-50.2. Administration of tuberculin purified protein derivative by nurses; policies and guidelines.

The Department shall issue policies and guidelines governing the possession and administration of tuberculin purified protein derivative (PPD) by registered nurses and licensed practical nurses pursuant to § 54.1-3408.

2003, c. 515.

§ 32.1-51. Repealed.

Repealed by Acts 1990, c. 958.

§ 32.1-53. Facilities and contracts for treatment of tuberculosis patients.

The Board may construct and operate hospitals and other facilities for the diagnosis and treatment of tuberculosis or enter into contractual arrangements with medical schools and hospitals in the Commonwealth for the care and treatment of tuberculosis patients.

Code 1950, § 32-312; 1979, c. 711.

§ 32.1-54. Commissioner authorized to charge patients for care.

When a tuberculosis patient is admitted to a facility operated by the Board or under contract with the Board, the Commissioner shall determine whether such patient or any person legally liable for such patient's support is able to pay in whole or in part for such patient's care. In making such determination the Commissioner shall consider whether such patient or other person can make such payment and meet his other financial responsibilities for the support of himself and his family. Such determination may be made from time to time according to the circumstances of each case. If the Commissioner determines that a patient or person legally liable for his support can pay for the cost of his care or a portion thereof, the Commissioner shall collect for the cost of such care the actual average per diem cost or such portion thereof as the Commissioner may determine the patient should pay. The Commissioner shall also collect any third-party payments as may be available for the care and treatment of such patient unless other contractual arrangements are made.

Code 1950, § 32-312.1; 1954, c. 698; 1956, c. 499; 1979, c. 711.

Article 5. Venereal Diseases.

§ 32.1-55. Definition.

As used in this article, "venereal disease" includes syphilis, gonorrhea, chancroid, granuloma inguinale, lymphogranuloma venereum and any other sexually transmittable disease determined by the Board to be dangerous to the public health.

Code 1950, § 32-90; 1979, c. 711.

§ 32.1-55.1. Anonymous testing sites for human immunodeficiency virus.

From such funds as are appropriated for this purpose, the Board of Health shall make available in all health services areas of the Commonwealth anonymous testing for infection with human immunodeficiency virus.

1989, c. 613.

§ 32.1-56. Information to be provided patients.

It shall be the duty of every physician or other person who examines or treats a person having a venereal disease to provide such person with information about the disease, including, as a minimum, the nature of the disease, methods of treatment, measures used in preventing the spread of such disease, and the necessity of tests to ensure that a cure has been accomplished.

Code 1950, § 32-92; 1979, c. 711.

§ 32.1-57. Examination, testing and treatment; failure to comply with order of examination.

A. A local health director may require any person suspected of being infected with any venereal disease to submit to examination, testing and treatment if necessary.

B. If any such person refuses to submit to an examination, testing or treatment or to continue treatment until found to be cured by proper test, the local health director may apply to the appropriate circuit court for an order compelling such examination, testing or treatment. Any person willfully failing to comply with such order shall be punishable as for contempt of court.

C. If a person infected with venereal disease is required by the local health director to receive treatment therefor and such person receives such treatment from the local health department, no fee shall be charged.

Code 1950, § 32-93; 1979, c. 711; 1988, c. 399.

§ 32.1-58. Persons convicted of certain crimes to be examined, tested and treated.

Each person convicted of a violation of § [18.2-346](#), [18.2-346.01](#), or [18.2-361](#) shall be examined and tested for venereal disease and treated if necessary.

Code 1950, § 32-94; 1979, c. 711; 2021, Sp. Sess. I, c. [188](#).

§ 32.1-59. Examination and treatment in certain institutions.

Every person admitted to any state correctional institution and every person admitted to a state hospital or training center operated by the Department of Behavioral Health and Developmental Services shall be examined and tested for venereal disease. If the person is found to be infected with a venereal disease, the person in charge of such institution or state hospital or training center shall promptly provide treatment and shall report such case as provided in § [32.1-37](#).

Code 1950, § 32-104; 1979, c. 711; 2012, cc. [476](#), [507](#).

§ 32.1-60. Prenatal tests required.

Every physician, physician assistant, or advanced practice registered nurse attending a pregnant woman during gestation shall examine and test such woman for such venereal diseases as the Board may designate within 15 days after beginning such attendance. Every other person permitted by law to attend upon pregnant women but not permitted by law to make such examinations and tests shall cause such examinations and tests to be made by a licensed physician, licensed advanced practice registered nurse, or clinic. Serological tests required by this section may be performed by the Department of General Services, Division of Consolidated Laboratory Services (DCLS).

Code 1950, § 32-104.1; 1950, p. 108; 1979, c. 711; 1980, c. 184; 1984, c. 140; 1993, c. 364; 2004, c. [855](#); 2006, c. [396](#); 2023, c. [183](#).

Article 6. Prevention of Blindness from Ophthalmia Neonatorum.

§ 32.1-61. Definition.

As used in this article, "ophthalmia neonatorum" means any inflammation, swelling or unusual redness in one or both eyes of any infant, either apart from or together with any unnatural discharge from the eye or eyes of such infant, independent of the nature of the infection, if any, occurring at any time within two weeks after the birth of such infant.

Code 1950, § 32-105; 1979, c. 711.

§ 32.1-62. Procedure upon infant's birth.

In order to prevent ophthalmia neonatorum, the physician, nurse or midwife in charge of the delivery of a baby or, if none, the first attending physician shall, immediately after the baby's birth, perform upon such baby the procedure prescribed by the Board. Such action shall be duly recorded in the medical record of the baby.

Code 1950, § 32-107; 1979, c. 711.

§ 32.1-63. Duty of physician, midwife or nurse noting ophthalmia neonatorum.

It shall be the duty of any physician, midwife or nurse who notes ophthalmia neonatorum within two weeks after the birth of an infant to perform or cause to be performed such tests as are necessary to ascertain the cause of such inflammation and to institute or have instituted appropriate therapy. When the cause of such inflammation is ascertained to be gonococcus, such physician, nurse or midwife shall report the infection to the local health director or the Commissioner as provided in § [32.1-36](#).

Code 1950, § 32-106; 1979, c. 711.

§ 32.1-64. Duty of Board to provide for treatment.

The Board shall provide for the gratuitous distribution of the necessary treatment approved by it for ophthalmia neonatorum, together with proper directions for the use and administration thereof, to all physicians, midwives and hospitals requesting it. The Board shall provide free of charge in medically indigent cases the necessary treatment for ophthalmia neonatorum when the cause is ascertained to be gonococcus.

Code 1950, § 32-109; 1979, c. 711.

Article 6.1. Virginia Hearing Loss Identification and Monitoring System.

§ 32.1-64.1. Virginia Hearing Loss Identification and Monitoring System.

A. In order to identify hearing loss at the earliest possible age among newborns and to provide early intervention for all infants so identified as having hearing loss, the Commissioner shall establish and maintain the Virginia Hearing Loss Identification and Monitoring System. This system shall be for the purpose of identifying and monitoring infants with hearing loss to ensure that such infants receive appropriate early intervention through treatment, therapy, training, and education.

B. The Virginia Hearing Loss Identification and Monitoring System shall be initiated in all hospitals with neonatal intensive care services, in all hospitals in the Commonwealth having newborn nurseries, and other birthing places or centers in the Commonwealth.

C. In all hospitals with neonatal intensive care services, the chief medical officer of such hospitals or his designee shall identify infants at risk of hearing loss using criteria established by the Board. Beginning on July 1, 1999, all infants shall be given a hearing screening test, regardless of whether or not the infant is at risk of hearing loss, by the chief medical officer or his designee using methodology approved by the Board. The test shall take place before the infant is discharged from the hospital to the care of the parent or guardian or as the Board may by regulation provide.

In all other hospitals and other birthing places or centers, the chief medical officer or his designee or the attending practitioner shall identify infants at risk of hearing loss using criteria established by the Board.

D. Beginning on July 1, 2000, the Board shall provide by regulation for the giving of hearing screening tests for all infants born in all hospitals. The Board's regulations shall establish when the testing shall be offered and performed and procedures for reporting.

An infant whose hearing screening indicates the need for a diagnostic audiological examination shall be offered such examination at a center approved by the Board of Health. As a condition of such approval such centers shall maintain suitable audiological support and medical and educational referral practices.

E. The Commissioner shall appoint an advisory committee to assist in the design, implementation, and revision of this identification and monitoring system. The advisory committee shall meet at least four times per year. A chairman shall be elected annually by the advisory committee. The Department of Health shall provide support services to the advisory committee. The advisory committee shall consist of representatives from relevant groups including, but not limited to, the health insurance industry; physicians, including at least one pediatrician or family practitioner, one otolaryngologist, and one neonatologist; nurses representing newborn nurseries; audiologists; hearing aid dealers and fitters; teachers of the deaf and hard of hearing; parents of children who are deaf or hard of hearing; adults who are deaf or hard of hearing; hospital administrators; and personnel of appropriate state agencies, including the Department of Medical Assistance Services, the Department of Education, and the Department for the Deaf and Hard-of-Hearing. The Department of Education, the Department for the Deaf and Hard-of-Hearing, and the Department of Behavioral Health and Developmental Services shall cooperate with the Commissioner and the Board in implementing this system.

F. With the assistance of the advisory committee, the Board shall promulgate such rules and regulations as may be necessary to implement this identification and monitoring system. These rules and regulations shall include criteria, including current screening methodology, for the identification of infants (i) with hearing loss and (ii) at risk of hearing loss and shall include the scope of the information to be reported, reporting forms, screening protocols, appropriate mechanisms for follow-up, relationships between the identification and monitoring system and other state agency programs or activities, and mechanisms for review and evaluation of the activities of the system. The identification

and monitoring system shall collect the name, address, sex, race, and any other information determined to be pertinent by the Board, for infants who are screened pursuant to this section.

G. In addition, the Board's regulations shall provide that any person making a determination that an infant (i) is at risk for hearing loss, (ii) has failed to pass a hearing screening, or (iii) was not successfully tested shall notify the parent or guardian of the infant, the infant's primary care practitioner, and the Commissioner. The Board may provide guidelines for the notification process.

H. No testing required to be performed or offered by this section shall be performed if the parents of the infant object to the test based on their bona fide religious convictions.

1986, c. 419; 1998, cc. [505](#), [506](#), [513](#); 2004, c. [855](#); 2009, cc. [813](#), [840](#); 2012, c. [147](#); 2019, c. [288](#).

§ 32.1-64.2. Confidentiality of records; publication; Commissioner required to contact parents, physicians, and relevant local early intervention program.

The Commissioner and all other persons to whom data is submitted pursuant to § [32.1-64.1](#) shall keep such information confidential. No publication of research or statistical data shall be made that identifies any infant with hearing loss or risk of hearing loss. The Commissioner shall contact the parents of children identified with hearing loss or at risk of hearing loss, their physicians, and the relevant local early intervention program to provide them with information about available public and private health care and educational resources, including any hearing loss clinics.

The Commissioner may authorize linkages between secure electronic data systems maintained by the Department of Health containing newborn hearing screening records and the Virginia Immunization Information System (VIIS) operated pursuant to § [32.1-46.01](#). The Commissioner may authorize health care providers authorized to view VIIS to view newborn hearing screening records of individuals to whom the providers are providing health care services. The records may be made available until the child reaches seven years of age, after which the records shall not be made available through a linkage to VIIS. Such linkages shall be subject to all applicable state and federal privacy laws and regulations.

1986, c. 419; 1998, cc. [505](#), [506](#), [513](#); 2012, c. [147](#); 2019, c. [288](#).

Article 7. Newborn Screening.

§ 32.1-65. Certain newborn screening required.

A. For the purposes of this section, "RUSP" means the federal Recommended Uniform Screening Panel recommended by the Secretary of the U.S. Department of Health and Human Services.

B. In order to prevent intellectual disability and permanent disability or death, every infant who is born in the Commonwealth shall be subjected to screening tests for various disorders consistent with, but not necessarily identical to, the RUSP recommended by the U.S. Secretary of Health and Human Services.

C. The Department shall ensure that testing for any disorder that is included on the RUSP as of January 1, 2025, is included in the testing required under this section if determined appropriate by the Department. For any disorder included on the RUSP, the Department shall:

1. Conduct an evaluation to determine whether the disorder should be included on the Commonwealth screening program, including an assessment of the estimated costs of including the disorder and a fiscal impact on the fee for the tests performed; and

2. If the Department determines the disorder should be included in the testing required under this section, commence the rulemaking process to add the disorder to the Commonwealth's screening program.

The Department shall conduct such evaluation and commence such rulemaking process, if applicable, within 12 months of the addition of any disorder added to the RUSP after January 1, 2025. If a condition is added to the Commonwealth's screening panel by rule, and there is an available test that meets all federal and state laboratory requirements for newborn screening programs, the Department shall implement screening for the condition in the Commonwealth's screening program within six months of completion of the rulemaking process. If there is not an available test that meets state and federal laboratory requirements for newborn screening programs, the program shall secure an appropriate test as soon as available.

D. For any disorder (i) included on the RUSP or (ii) evaluated pursuant to the process established by subsection E that the Department determines in an initial evaluation should not be included under the Commonwealth's screening program, the Department shall determine whether reevaluation is necessary by (a) reviewing the medical literature published on the disorder since the initial evaluation and (b) allowing for public input. The Department shall conduct such determination annually. If the Department determines reevaluation is necessary during such annual determination, the Department shall conduct an evaluation and commence the rulemaking process, if applicable, within 12 months pursuant to subsection C. The Department shall not include in the testing required under this section any disorder not included on the RUSP unless it has first conducted an evaluation and commenced the rulemaking process to add the disorder in the same manner as is required for any disorder included on the RUSP in accordance with subsection C.

E. In addition to disorders included on the RUSP, the Department shall establish a process for considering the addition of other disorders to the Commonwealth's screening program that are not included on the RUSP. The process shall include (i) criteria for which disorders shall be considered, including the availability of a newborn screening assay and a treatment approved by the U.S. Food and Drug Administration, (ii) a timeline for consideration of these disorders, and (iii) a timeline for initiating rulemaking following the consideration of a disorder. The Department shall consult with the Newborn Screening Advisory Committee and other relevant stakeholders as deemed appropriate by the Department in developing this process.

F. The Department shall submit a status report to the General Assembly on the screening program annually. Such status report shall include:

1. The current disorders included under the Commonwealth's screening program;
2. Any new disorders currently under consideration or recommended for inclusion under the Commonwealth's screening program;
3. Any new disorders considered but not recommended for inclusion in the Commonwealth's screening program in the prior 12-month period and the reason for not recommending such disorders;
4. Any disorders for which the Department determined a reevaluation was unnecessary in the prior 12-month period and the reason that such reevaluation is not necessary at the time of such determination;

and

5. Any delay in complying with the timeframes specified by this section for evaluation, inclusion, or reevaluation of a disorder and the reason for such delay.

G. Any infant whose parent or guardian objects thereto on the grounds that such tests conflict with his religious practices or tenets shall not be required to receive such screening tests.

H. The physician, licensed midwife, or certified nurse midwife in charge of the infant's care after delivery shall cause such tests to be performed. The screening tests shall be performed by the Division of Consolidated Laboratory Services or any other laboratory the Department of Health has contracted with to provide such service. Screening tests for time-critical disorders identified by the U.S. Department of Health and Human Services shall be performed seven days a week.

I. The program for screening infants for sickle cell diseases shall be conducted in addition to the programs provided for in Article 8 (§ 32.1-68 et seq.).

Code 1950, §§ 32-112.1, 32-112.9; 1966, c. 179; 1979, c. 711; 1983, c. 582; 1986, c. 172; 1988, c. 97; 1990, cc. 747, 873; 2001, c. 255; 2002, c. 440; 2004, c. 760; 2005, cc. 717, 721; 2012, cc. 147, 476, 507; 2018, c. 531; 2025, c. 483; 2026, c. 392.

§ 32.1-65.1. Critical congenital heart defect screening test required.

In order to prevent disability or death, the Board shall require every hospital in the Commonwealth having a newborn nursery to perform a critical congenital heart defect screening test using pulse oximetry or other Board-approved screening test that is based on standards set forth by the American Academy of Pediatrics on every newborn in its care when such infant is at least 24 hours old but no more than 48 hours old or, in cases in which the infant is discharged from the hospital prior to reaching 24 hours of age, prior to discharging the infant.

Any infant whose parent or guardian objects thereto on the grounds that such tests conflict with his religious practices or tenets shall not be required to receive such screening tests.

The physician or health care provider in charge of the infant's care after delivery shall cause such tests to be performed.

2014, cc. 4, 175.

§ 32.1-66. Commissioner to notify physicians; reports to Commissioner.

Whenever a newborn screening test result indicates suspicion of any condition pursuant to § 32.1-65, the Commissioner shall notify forthwith the attending physician and shall perform or provide for additional testing required to confirm or disprove the diagnosis. All physicians, certified nurse midwives, public health nurses, or any nurse receiving such test result, and administrators of hospitals in the Commonwealth, shall report the discovery of all cases of any condition for which newborn screening is conducted pursuant to § 32.1-65 to the Commissioner for infants and children up to two years of age.

Code 1950, § 32-112.5; 1966, c. 179; 1979, c. 711; 1986, c. 172; 1988, c. 97; 2005, cc. 717, 721.

§ 32.1-67. Duty of Board for follow-up and referral protocols; regulations.

Infants identified with any condition for which newborn screening is conducted pursuant to § 32.1-65 shall be eligible for the services of the Children with Special Health Care Needs Program administered by the Department of Health. The Board of Health shall promulgate such regulations as may be necessary to implement Newborn Screening Services and the Children with Special Health Care Needs Program. The Board's regulations shall include a list of newborn screening tests conducted pursuant to §§ 32.1-65 and 32.1-65.1 and authorization to charge fees for such tests, notification processes conducted pursuant to § 32.1-66, follow-up procedures, appropriate referral processes, and services available for infants and children who have a heritable disorder or genetic disease identified through Newborn Screening Services.

Code 1950, § 32-112.6; 1966, c. 179; 1979, c. 711; 1980, c. 470; 1981, c. 164; 1986, c. 172; 1988, c. 97; 2000, c. 916; 2005, cc. 717, 721; 2012, c. 147; 2014, cc. 4, 175; 2025, c. 483.

§ 32.1-67.1. Confidentiality of records; prohibition of discrimination.

The results of the newborn screening services conducted pursuant to this article may be used for research and collective statistical purposes. No publication of research or statistical data shall be made that identifies any infant having a heritable or genetic disorder.

The Commissioner may authorize linkages between secure electronic data systems maintained by the Department of Health containing newborn screening records and the Virginia Immunization Information System (VIIS) operated pursuant to § 32.1-46.01. The Commissioner may authorize health care providers authorized to view VIIS to view the newborn screening records of individuals to whom the providers are providing health care services. The records may be made available until the child reaches seven years of age, after which the records shall not be made available through a linkage to VIIS. Such linkages shall be subject to all applicable state and federal privacy laws and regulations.

1988, c. 97; 2005, cc. 717, 721; 2012, c. 147.

Article 8. Voluntary Program for Control of Genetic and Metabolic Diseases.

§ 32.1-68. Commissioner to establish screening and treatment program; review by Board; program to include education and post-screening counseling; laboratory tests.

A. The Commissioner, in cooperation with local health directors, shall establish a voluntary program for the screening of adults and children for the disease of sickle cell anemia or the sickle cell trait and for such other genetically related diseases and genetic traits and inborn errors of metabolism as the Board may deem necessary.

B. The Board shall review the program from time to time to determine the appropriate age and the method of screening for such conditions or traits in the light of technological changes.

C. The screening program shall include provisions for education concerning the nature and treatment of sickle cell anemia, other genetically related diseases and inborn errors of metabolism and a post-screening counseling program for the treatment of any person determined to have such a condition. Such education shall also address cancers known to be more common in individuals with sickle cell disease or the sickle cell trait, including certain types of kidney cancer.

D. The program may include the provision of laboratory testing.

E. The program shall offer educational resources to health care providers who screen individuals for sickle cell disease or the sickle cell trait about the increased risks for certain cancers among individual with those conditions. The resources shall be culturally and linguistically appropriate and shall include information for providers, affected individuals, and their families regarding (i) cancers known to be more common in individuals with sickle cell disease or the sickle cell trait, including certain types of kidney cancer; (ii) signs, symptoms, and surveillance for such cancers; (iii) how to access referral resources for treatment for such cancers; and (iv) the importance of individuals and their families communicating concerns about such cancers to providers. Nothing in this subsection shall be construed to prevent the program or a health care provider from offering more frequent or additional education for sickle cell disease or the sickle cell trait.

F. The Board shall adopt regulations to implement an adult and pediatric comprehensive sickle cell clinic network.

Code 1950, §§ 32-112.21, 32-112.22; 1973, c. 212; 1979, c. 711; 2020, c. 503; 2026, c. 600.

§ 32.1-69. Records confidential; disclosure of results of screening.

The results of any particular screening program shall be sent to the physician of the person tested, if known, and either to the parents when the person screened is under the age of eighteen or to the person if he is eighteen years of age or over. The results of a screening program may be used for research and collective statistical purposes. Except as hereinabove provided, all records maintained as part of any screening program shall be strictly confidential and shall be accessible only to the Board, the Commissioner or his agents or to the local health director who is conducting the screening program except by explicit permission of the person who has been screened if such person is eighteen years of age or over or of such person's parent or guardian if he is under age eighteen.

Code 1950, § 32-112.23; 1973, c. 212; 1979, c. 711.

Article 8.1. Virginia Congenital Anomalies Reporting and Education System.

§ 32.1-69.1. Virginia Congenital Anomalies Reporting and Education System.

A. In order to collect data to evaluate the possible causes of stillbirths and birth defects, improve the diagnosis and treatment of birth defects, and establish a mechanism for informing the parents of children identified as having birth defects and their physicians about the health resources available to aid such children, the Commissioner shall establish and maintain a Virginia Congenital Anomalies Reporting and Education System using data from birth and death certificates and fetal death reports filed with the State Registrar of Vital Records and data obtained from hospital medical records. The chief administrative officer of every hospital, as defined in § 32.1-123, shall make or cause to be made a report to the Commissioner of any stillbirth and any person under two years of age diagnosed as having a congenital anomaly. The Commissioner may appoint an advisory committee to assist in the design and implementation of this reporting and education system with representation from relevant groups, including, but not limited to, physicians, geneticists, personnel of appropriate state agencies, persons with disabilities, and the parents of children with disabilities.

B. The Commissioner shall provide for a secure system, which may include online data entry that protects the confidentiality of data and information for which reporting is required, to implement the Virginia Congenital Anomalies Reporting and Education System.

At a minimum, data collected shall include, but need not be limited to, the following: (i) the infant's first and last name, date of birth, gender, state of residence, birth hospital, physician's name, date of admission, date of discharge or transfer, and diagnosis; (ii) the first and last names of the infant's parents; (iii) the first and last name of the primary contact person for the infant; and (iv) data pertaining to stillbirths and birth defects reported by hospitals and derived from birth and death certificates and fetal death reports filed with the State Registrar of Vital Records and such other sources as may be authorized by the Commissioner.

The Commissioner, as he deems necessary to facilitate the follow-up of infants whose data and health record information have been entered into the system, may authorize the integration or linking of the Virginia Congenital Anomalies Reporting and Education System with other Department of Health population-based surveillance systems.

In addition, to minimize duplication and ensure accuracy during data entry, the Commissioner may authorize hospitals required to report stillbirth and birth defect data to the system to view such existing data and information as may be designated by the Commissioner.

With the assistance of the advisory committee, the Board shall promulgate such regulations as may be necessary to implement this reporting and education system.

C. As used in this section, "stillbirth" means an unintended, intrauterine fetal death occurring after a gestational period of 20 weeks.

1985, c. 273; 1986, c. 136; 1988, cc. 459, 843; 1994, c. 854; 2006, cc. 699, 906; 2015, c. 661; 2020, c. 900.

§ 32.1-69.1:1. Dissemination of information regarding birth defects.

The Commissioner shall develop a publication concerning the role of folic acid in the prevention of birth defects for distribution to physicians, hospitals and other medical facilities, and local health departments for use with patients. The publication shall be distributed by the Virginia Department of Health to the offices of the clerks of the circuit courts and made available to applicants for marriage licenses.

1999, c. 582; 2012, c. 802.

§ 32.1-69.2. Confidentiality of records; publication; authority of Commissioner to contact parents and physicians.

The Commissioner and all other persons to whom data is submitted pursuant to § 32.1-69.1 shall keep such information confidential. For the purpose of only complying with the provisions of § 32.1-69.1, hospitals required to report stillbirths, as defined in § 32.1-69.1, and birth defects to the Virginia Congenital Anomalies Reporting and Education System and provide patient follow-up may view personally identifiable information in the system as approved by the Commissioner and upon receipt by the Commissioner of sworn affirmation from each such person that the confidentiality of the information will be preserved. No publication of information shall be made except in the form of statistical or other studies which do not identify individuals. However, the Commissioner may contact the parents of children identified as having birth defects and their physicians to collect relevant data and to provide them with information about available public and private health care resources.

1985, c. 273; 2006, cc. 699, 906; 2015, c. 661.

Article 8.2. Virginia Cord Blood Bank Initiative.

§ 32.1-69.3. Virginia Cord Blood Bank Initiative established.

A. There is hereby established the Virginia Cord Blood Bank Initiative (the Initiative) as a public resource for the treatment of patients with life-threatening diseases or debilitating conditions, for use in advancing basic and clinical research, and, in the event of a terrorist attack, to be used in the treatment of the injured.

The Initiative shall be established as a nonprofit legal entity to collect, screen for infectious and genetic diseases, perform tissue typing on, cryopreserve, and store umbilical cord blood as a public resource and shall be formed as a collaborative consortium that covers all geographical regions of Virginia.

B. The State Health Commissioner shall develop or shall arrange for or contract with a nonprofit entity for the development of the collaborative consortium to be known as the Initiative, which may consist of any entity having the expertise or experience or willingness to develop the expertise or experience necessary to participate in the Initiative.

C. In developing the consortium, the Commissioner shall ensure that all geographical areas of the Commonwealth are included in the Initiative. To accomplish this goal, the Commissioner shall contact Virginia Health Sciences at Old Dominion University and its participating hospitals, Virginia Commonwealth University School of Medicine, Virginia Commonwealth University Health System, the University of Virginia School of Medicine, the University of Virginia Health System, and other entities located in Virginia, such as hospitals and hospital systems, biotechnology companies, regional blood banks, laboratories, or other health care providers or medical researchers, or local coalitions of health care providers that could provide coverage of the various geographical regions of Virginia, to request their participation in the Initiative consortium and assist in the design and implementation of the Initiative.

D. Any nonprofit entity having an arrangement or contract with the Commissioner for the development of the Initiative and any medical school, hospital, or other health care provider choosing to participate in the Initiative shall submit an estimate of the costs of implementing the Initiative for the region in which it is located. The Commissioner shall assist in the development of the cost estimates, compare and evaluate such estimates, and negotiate with the various entities to implement the Initiative.

Further, the Commissioner shall coordinate (i) appropriate contact with pregnant women to provide information about umbilical cord blood donations; (ii) the development of procedures for obtaining informed consent for cord blood donations; (iii) the design of the Initiative, including the period of years for storage of the cord blood to ensure the integrity of the cells; (iv) a system for recycling the blood at the end of the established storage period that provides for the sale or transfer of the cord blood samples being taken out of storage to be used in basic or clinical research development at reasonable rates and fees for cord blood products.

E. The entities joining the Initiative shall work collaboratively, each with the community resources in its local or regional area. The Initiative participants shall align their outreach programs and activities to its geographic areas and ethnic and racial groups of the Commonwealth, and shall conduct specific and culturally appropriate outreach and research to identify potential donors among all ethnic and racial groups.

F. The Commissioner shall disseminate information about the Initiative, focusing on hospitals, birth facilities, physicians, midwives, and nurses, and providing information through local health departments.

Initiative consortium participants shall also be encouraged to disseminate information about the Initiative.

In addition, the Director of the Department of Medical Assistance Services shall include information about the Initiative in printed materials distributed by the Department to recipients of medical assistance services and persons enrolled in the Family Access to Medical Insurance Security Plan.

G. Any woman admitted to a hospital or birthing facility for obstetrical services may be offered the opportunity to donate umbilical cord blood to the Initiative. However, no woman shall be required to make a cord blood donation.

H. Any health care facility or health care provider receiving financial remuneration for the collection of umbilical cord blood shall, prior to harvesting the umbilical cord blood, disclose this information in writing to any woman postpartum or to the parent of a newborn from whom the umbilical cord blood is to be collected.

I. This section shall not be construed to require participation in the Initiative on the part of any health care facility or health care provider who objects to transfusion or transplantation of blood on the basis of bona fide religious beliefs.

J. The Initiative shall be implemented with such funds as may be appropriated or otherwise provided for its purpose. Upon implementation, the Commissioner shall initiate the development of a nonprofit entity to assume the operation and administration of the Initiative and may seek federal, state, and private grant funds for its continuation.

2006, cc. [636](#), [735](#); 2008, c. [285](#); 2023, cc. [756](#), [778](#); 2026, c. [482](#).

§ 32.1-69.4. Publication of information regarding cord blood education.

In addition to the requirements of § [32.1-69.3](#), the Commissioner shall make publicly available, by posting on the public website of the Department of Health, resources relating to umbilical cord blood that have been developed by the Parent's Guide to Cord Blood Foundation and include the following information:

1. An explanation of the potential value and uses of umbilical cord blood, including cord blood cells and stem cells, for individuals who are, as well as individuals who are not, biologically related to a mother and her newborn child.
2. An explanation of the differences between using one's own cord blood cells and using related or unrelated cord blood stem cells in the treatment of disease.
3. An explanation of the differences between public and private umbilical cord blood banking.
4. The options available to a mother relating to stem cells that are contained in the umbilical cord blood after the delivery of her newborn, including (i) donating the stem cells to a public umbilical cord blood bank where facilities are available; (ii) storing the stem cells in a private family umbilical cord blood

bank for use by immediate and extended family members; (iii) storing the stem cells for immediate or extended family members through a family or sibling donor banking program that provides free collection, processing, and storage where there is an existing medical need; and (iv) discarding the stem cells.

5. The medical processes involved in the collection of cord blood.

6. Medical or family history criteria that can impact a family's consideration of umbilical cord blood banking, including the likelihood of using a baby's cord blood to serve as a match for a family member who has a medical condition.

7. Options for ownership and future use of donated umbilical cord blood.

8. The average cost of public and private umbilical cord blood banking.

9. The availability of public and private cord blood banks to Virginians, including (i) a list of public cord blood banks and the hospitals served by such banks; (ii) a list of private cord blood banks that are available; and (iii) the availability of free family banking and sibling donor programs where there is an existing medical need by a family member.

10. An explanation of which racial and ethnic groups are in particular need of publicly donated cord blood samples based upon medical data developed by the U.S. Health Resources and Services Administration.

2010, c. 69.

Article 9. Statewide Cancer Registry.

§ 32.1-70. Information from hospitals, clinics, certain laboratories and physicians supplied to Commissioner; statewide cancer registry.

A. Each hospital, clinic and independent pathology laboratory shall make available to the Commissioner or his agents information on patients having malignant tumors or cancers. A physician shall report information on patients having cancers unless he has determined that a hospital, clinic or in-state pathology laboratory has reported the information. This reporting requirement shall not apply to basal and squamous cell carcinoma of the skin. Such information shall include the name, address, sex, race, diagnosis and any other pertinent identifying information regarding each such patient and shall include information regarding possible exposure to Agent Orange or other defoliants through their development, testing or use or through service in the Vietnam War. Each hospital, clinic, independent pathology laboratory, or physician shall provide other available clinical information as defined by the Board of Health.

B. From such information the Commissioner shall establish and maintain a statewide cancer registry. The purpose of the statewide cancer registry shall include but not be limited to:

1. Determining means of improving the diagnosis and treatment of cancer patients.

2. Determining the need for and means of providing better long-term, follow-up care of cancer patients.

3. Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.
4. Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.
5. Collecting data to evaluate potential links between exposure to fire incidents and cancer incidence.
6. Improving rehabilitative programs for cancer patients.
7. Assisting in the training of hospital personnel.
8. Determining other needs of cancer patients and health personnel.

Code 1950, § 32-388; 1950, p. 187; 1978, c. 792; 1979, c. 711; 1988, cc. 447, 459, 843; 1998, c. 315; 2018, 459.

§ 32.1-70.1. Repealed.

Repealed by Acts 1998, c. 315.

§ 32.1-70.2. Collection of cancer case information by the Commissioner.

A. Using such funds as may be appropriated therefor, the Commissioner or his designee may perform on-site data collection of the records of patients having malignant tumors or cancers at those consenting hospitals, clinics, independent pathology laboratories and physician offices required to report information of such patients pursuant to the reporting requirements of § 32.1-70, in order to ensure the completeness and accuracy of the statewide cancer registry.

B. The selection criteria for determining which consenting hospitals, clinics, independent pathology laboratories and physician offices may be subject to on-site data collection under the provisions of this section shall include, but shall not be limited to: (i) expected annual number of cancer case reports, (ii) historical completeness and accuracy of reporting rates, and (iii) whether the facility maintains its own cancer registry.

C. The Board of Health shall promulgate regulations necessary to implement the provisions of this section.

2000, cc. 74, 139.

§ 32.1-71. Confidential nature of information supplied; publication; reciprocal data-sharing agreements.

A. The Commissioner and all persons to whom information is submitted in accordance with § 32.1-70 shall keep such information confidential. Except as authorized by the Commissioner in accordance with the provisions of § 32.1-41, no release of any such information shall be made except in the form of statistical or other studies which do not identify individual cases.

B. The Commissioner may enter into reciprocal data-sharing agreements with other cancer registries for the exchange of information. Upon the provision of satisfactory assurances for the preservation of the confidentiality of such information, patient-identifying information may be exchanged with other cancer registries which have entered into reciprocal data-sharing agreements with the Commissioner.

Code 1950, § 32-389; 1950, p. 187; 1979, c. 711; 1991, c. 319; 2000, cc. 74, 139.

§ 32.1-71.01. Penalties for unauthorized use of statewide cancer registry.

In addition to the remedies provided in § 32.1-27, any person who uses, discloses or releases data maintained in the statewide cancer registry in violation of § 32.1-71 shall be subject, in the discretion of the court, to a civil penalty not to exceed \$25,000 for each violation, which shall be paid to the general fund.

2000, cc. 74, 139.

§ 32.1-71.02. Notification of cancer patients of statewide cancer registry reporting.

A. Any physician diagnosing a malignant tumor or cancer shall, at such time and in such manner as considered appropriate by such physician, notify each patient whose name and record abstract is required to be reported to the statewide cancer registry pursuant to § 32.1-70 that personal identifying information about him has been included in the registry as required by law. Any physician required to notify a patient that personal identifying information about him has been included in the cancer registry may, when, in the opinion of the physician, such notice would be injurious to the patient's health or well-being, provide the required notice to the patient's authorized representative or next of kin in lieu of notifying the patient.

B. Upon request to the statewide cancer registry, the patient whose personal identifying information has been submitted to such registry shall have a right to know the identity of the reporter of his information to such registry.

2000, c. 918; 2003, cc. 540, 548.

Article 9.1. Statewide Alzheimer's Disease and Related Disorders Registry.

§ 32.1-71.1. Repealed.

Repealed by Acts 1994, c. 109.

Article 9.2. Research and Clinical Trial Cancer Consortium Initiative.

§ 32.1-71.5. Research and Clinical Trial Cancer Consortium Initiative; purpose.

A. As used in this article, "Initiative" means the Research and Clinical Trial Cancer Consortium Initiative established pursuant to this article.

B. The Research and Clinical Trial Cancer Consortium Initiative is hereby established as an independent nonprofit entity in the Commonwealth for the purpose of coordinating, maximizing the efficiency of, and facilitating cancer clinical research and treatment efforts across the Commonwealth. The Initiative shall include the Massey Comprehensive Cancer Center at Virginia Commonwealth University, the University of Virginia Medical Center, the Leroy T. Canoles Jr. Cancer Research Center at Virginia Health Sciences at Old Dominion University, the Fralin Biomedical Research Institute at Virginia Tech Carilion Research Center, and three nonacademic health systems.

2025, c. 630; 2026, c. 482.

§ 32.1-71.6. Membership; powers and duties of the Initiative; report.

A. The Initiative shall have a total membership of 12 members that shall consist of eight representatives of health or medical institutions with expertise in cancer clinical research and treatment, three nonlegislative citizen members with expertise in cancer clinical research and treatment or philanthropic support of cancer clinical research and treatment, and one ex officio member. The representatives of health or medical institutions with expertise in cancer clinical research and treatment shall be appointed by the Commissioner as follows: one representative each from (i) the Massey Comprehensive Cancer Center at Virginia Commonwealth University, (ii) the University of Virginia Medical Center, (iii) the Leroy T. Canoles Jr. Cancer Research Center at Virginia Health Sciences at Old Dominion University, (iv) the Fralin Biomedical Research Institute at Virginia Tech Carilion, (v) Hampton University, and (vi) three nonacademic health systems. The nonlegislative citizen members shall be appointed as follows: three members with expertise in cancer clinical research and treatment or philanthropic support of cancer clinical research and treatment, one of whom shall be appointed by the Senate Committee on Rules, one of whom shall be appointed by the Speaker of the House of Delegates, and one of whom shall be appointed by the Governor, subject to confirmation by the General Assembly. The Secretary of Health and Human Resources shall serve ex officio with voting privileges. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years. No nonlegislative citizen member shall serve more than two consecutive four-year terms. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment.

B. The Initiative shall elect a chairman from among its membership, provided, however, that no institutional representative appointed as a member shall be eligible to serve as chairman of the Initiative. A majority of the members shall constitute a quorum. Members shall serve without compensation but shall be reimbursed for actual expenses incurred in the performance of their duties.

C. The Initiative shall have the power and duty to:

1. Develop and provide coordinated financial incentives to the medical and health institutions focused on cancer clinical research and treatment in the Commonwealth to (i) collaborate on clinical trials in the areas with the most significant demonstrated need; (ii) leverage existing resources; (iii) incentivize the development of intellectual property research and associated patents relating to cancer clinical research and treatment created within the Commonwealth; (iv) combine clinical enrollment participation populations to increase efficiency and maximize the receipt of available federal funding; and (v) develop and implement plans and procedures for minimizing duplicative research efforts across institutions in the Initiative;

2. Take such actions as deemed necessary and appropriate to further the Initiative's purpose of coordinating, maximizing the efficiency of, and facilitating cancer clinical research and treatment efforts across the Commonwealth, including (i) developing and implementing plans designed to expand outreach and improve efforts to attract highly qualified individuals with expertise in cancer clinical research and treatment to the Commonwealth and (ii) developing policies and model contracts to streamline and facilitate the assignment and sharing of intellectual property research and foster the

utilization of information, discoveries, data, and material produced or performed by institutions in the Initiative; and

3. Submit an annual report to the Governor and the General Assembly for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The chairman of the Initiative shall submit to the Governor and the General Assembly an annual executive summary of the activity and work of the Initiative for the immediately preceding year no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

2025, c. [630](#); 2026, c. [482](#).

Article 10. Laboratory Tests.

§ 32.1-72. Repealed.

Repealed by Acts 1992, cc. 747 and 873.

Article 11. Penalty.

§ 32.1-73. Failure to comply with provisions; grounds for revocation of license or permit.

The failure of any physician, nurse or midwife to comply with the provisions of § [32.1-60](#), § [32.1-62](#) or [32.1-65](#) shall, in addition to any other penalty prescribed by law, constitute grounds for revocation of the license or permit of such physician, nurse or midwife by the board issuing such license or permit.

1979, c. 711.

Article 12. The Commonwealth Neurotrauma Initiative.

§ 32.1-73.1. Repealed.

Repealed by Acts 2002, c. [60](#).

Article 13. Statewide Asthma Management.

§ 32.1-73.5. Comprehensive statewide asthma management plan.

A. Using such funds as may be appropriated therefor, the Commissioner shall develop, maintain, and revise biennially a written comprehensive state plan for (i) reducing the rate of hospitalizations due to asthma and (ii) facilitating the effective management of persons with asthma residing in the Commonwealth. The plan shall address, but shall not be limited to, disease surveillance and investigation, public and professional education, identification and replication of best practices for public health and clinical interventions, public and private partnerships with health care providers, third-party payors, local school divisions, and community coalitions, and identification of sources of grant funding. The plan shall place primary emphasis on, but not be limited to, children between the ages of birth and eighteen years.

B. In order to develop the comprehensive state plan, the Commissioner shall consult with representatives of the medical, nursing, pharmacy and allied health professions, public health agencies

community coalition leaders, insurers, hospital personnel, the Department of Education and local school divisions, and other appropriate entities.

2000, cc. [73](#), [134](#).

§ 32.1-73.6. Implementation of state asthma management programs.

A. Using such funds as may be appropriated for this purpose, the Commissioner shall implement programs to meet the objectives of the statewide asthma management plan. The Commissioner shall assure, to the extent feasible and appropriate, that existing Department programs, systems, and infrastructure are efficiently utilized as a basis for implementation.

B. The Board shall promulgate regulations as necessary to implement the provisions of the statewide asthma management plan.

C. The Commissioner shall report periodically to the Board concerning (i) the development and implementation of the statewide asthma management plan and (ii) the effectiveness of the Department programs in reducing the rate of hospitalizations due to asthma in the Commonwealth and facilitating more effective management of asthma.

2000, cc. [73](#), [134](#).

Article 14. Youth Suicide Prevention.

§ 32.1-73.7. Department to be lead agency for youth suicide prevention.

With such funds as may be appropriated for this purpose, the Department, in consultation with the Department of Education, the Department of Behavioral Health and Developmental Services, community services boards and behavioral health authorities, and local departments of health, shall have the lead responsibility for the youth suicide prevention program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining youth suicide prevention in order to develop and carry out comprehensive youth suicide prevention strategies addressing public awareness, the promotion of health development, early identification, intervention and treatment, and support to survivors. The strategies shall be targeted to the specific needs of children and adolescents. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested persons in order to prevent youth suicide within the Commonwealth.

The provisions of this section shall not limit the powers and duties of other state agencies.

2001, cc. [275](#), [291](#); 2003, c. [885](#); 2005, cc. [336](#), [434](#); 2009, cc. [813](#), [840](#).

Article 15. Youth Health Risk Behavior Survey.

§ 32.1-73.8. Youth health risk behavior survey.

The Department shall, in cooperation with the Department of Behavioral Health and Developmental Services and the Superintendent of Public Instruction, develop and administer a survey of students to facilitate planning and implementation of effective programs for the prevention of substance abuse through collection of data and information to (i) identify trends in the use of alcohol, tobacco, and other drugs and (ii) assess the prevalence of risk and protective factors among the youth of the Commonwealth. In developing such survey, the Department may utilize all or part of an existing survey.

designed to collect such information developed by the Centers for Disease Control and Prevention. The survey shall be anonymous and administered in a manner designed to protect students' privacy. Schools shall be randomly selected for participation in the survey. Schools selected to participate in the survey shall notify students and parents pursuant to § 22.1-79.3. A student whose parents have refused to consent to the student's participation in the survey as provided in § 22.1-79.3 shall not be required to participate in the survey.

2011, c. 726.

Article 16. Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-Onset Neuropsychiatric Syndrome.(Expires July 1 2028).

§ 32.1-73.9. (Expires July 1, 2028) Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome; membership.

A. There is hereby created in the executive branch of state government the Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome (the Advisory Council), for the purpose of advising the Commissioner of Health on research, diagnosis, treatment, and education relating to pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome.

B. The Advisory Council shall have a total membership of 16 members that shall consist of six legislative members, nine nonlegislative citizen members, and one ex officio member. Members shall be appointed as follows: four members of the House of Delegates to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; two members of the Senate to be appointed by the Senate Committee on Rules; and the following nine nonlegislative citizen members to be appointed by the Governor: one licensed health care provider who has expertise in treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome and autism; one pediatrician who has experience treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; one child psychiatrist who has experience treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; one immunologist with experience in treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome and the use of intravenous immunoglobulin; one medical researcher with experience conducting research concerning pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, obsessive-compulsive disorder, tic disorder, and other neurological disorders; one representative of a professional organization for school nurses in the Commonwealth; one representative of an advocacy and support group for individuals affected by pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; one representative of an advocacy and support group for individuals affected by autism; and one parent of

child who has been diagnosed with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome and autism. The Commissioner of Health or his designee shall serve ex officio without voting privileges. Nonlegislative members shall be citizens of the Commonwealth.

Legislative members and the ex officio member of the Advisory Council shall serve terms coincident with their terms of office. Nonlegislative members shall be appointed for terms of two years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed.

C. Legislative members of the Advisory Council shall receive such compensation as provided in § 30-19.12. Nonlegislative members shall serve without compensation or reimbursement.

D. The Advisory Council shall elect a chairman and a vice-chairman annually from among its legislative membership. A majority of the members shall constitute a quorum. The Advisory Council shall meet at such times as may be called by the chairman or a majority of the Advisory Council.

E. Staff to the Advisory Council shall be provided by the Department of Health. All agencies of the Commonwealth shall provide assistance to the Advisory Council, upon request.

2017, c. 466.

§ 32.1-73.10. (Expires July 1, 2028) Advisory Council; report.

The Advisory Council shall report to the Governor and the General Assembly, by December 1 of each year, on the Advisory Council's recommendations related to:

1. Practice guidelines for the diagnosis and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome;
2. Mechanisms to increase clinical awareness and education regarding pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome among physicians, including pediatricians, school-based health centers, and providers of mental health services;
3. Outreach to educators and parents to increase awareness of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; and
4. Development of a network of volunteer experts on the diagnosis and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome to assist in the delivery of education and outreach.

2017, c. 466.

§ 32.1-73.11. (Continued pursuant to Acts 2022, Sp. Sess. I, c. 2, Item 299 D; expires July 1, 2028 Sunset.

This article shall expire on July 1, 2028.

2017, c. [466](#); 2024, c. [391](#).

Article 17. Substance-Exposed Infants.

§ 32.1-73.12. Department to be lead agency for services for substance-exposed infants.

The Department shall serve as the lead agency with responsibility for the development, coordination, and implementation of a plan for services for substance-exposed infants in the Commonwealth. Such plan shall support a trauma-informed approach to identification and treatment of substance-exposed infants and their caregivers and shall include options for improving screening and identification of substance-using pregnant women; use of multidisciplinary approaches to intervention and service delivery during the prenatal period and following the birth of the substance-exposed child; and referral among providers serving substance-exposed infants and their families and caregivers. In carrying out duties, the Department shall work cooperatively with the Department of Social Services, the Department of Behavioral Health and Developmental Services, community services boards and behavioral health authorities, local departments of health, the Virginia Chapter of the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, Virginia Section, and such other stakeholders as may be appropriate. The Department shall report annually on December 1 to the General Assembly regarding implementation of the plan.

2018, cc. [695](#), [696](#).

Article 18. Alzheimer's Disease.

§ 32.1-73.13. Alzheimer's disease and related dementias; early detection and diagnosis; risk reduction and care planning.

Using such funds as may be available for such purpose, the Department, in consultation with the Department for Aging and Rehabilitative Services, shall have the lead responsibility for (i) educating and informing the public, based on evidence-based public health research and data, about Alzheimer's disease and related dementias; (ii) supporting early detection and diagnosis of Alzheimer's disease and related dementias; (iii) reducing the risk of potentially avoidable hospitalizations for individuals with Alzheimer's disease and related dementias; (iv) reducing the risk of cognitive decline and cognitive impairment associated with Alzheimer's disease and related dementias; and (v) supporting care planning and management for individuals with Alzheimer's disease and related dementias. The Department shall use targeted strategies specific to the needs of persons with Alzheimer's disease and related dementias. The Department shall cooperate with federal, state, and local agencies, private and public agencies, and other interested persons in order to address and reduce the risks and impairment associated with Alzheimer's disease and related dementias within the Commonwealth.

The provisions of this section shall not limit the powers and duties of other state agencies.

2020, c. [854](#).

Article 19. Rare Disease Council.

§ 32.1-73.14. Rare Disease Council; purpose.

There is hereby created in the executive branch of state government the Rare Disease Council (the Council) for the purpose of (i) advising the Governor and the General Assembly on the needs of individuals with rare diseases in the Commonwealth; (ii) identifying challenges that such individuals

face, including delays in obtaining a diagnosis or the receipt of a misdiagnosis, shortages of medical specialists who can provide treatment, and lack of access to therapies and medication used to treat rare diseases; (iii) funding research related to rare diseases and the development of new treatments for rare diseases; and (iv) funding for supports for persons with rare diseases in the Commonwealth.

2021, Sp. Sess. I, c. [303](#).

§ 32.1-73.15. Powers and duties of the Council.

The Council shall have the power and duty to:

1. Within the first year, hold public hearings and make inquiries of and solicit comments from the public to assist the Council in understanding the scope of rare diseases in the Commonwealth and the impact of rare diseases on individuals in the Commonwealth.
2. Conduct research and consult with experts to develop policy recommendations related to:
 - a. Improving access to health care and other services for individuals with rare diseases, including access to health insurance, specialists, health care services, and other necessary services for individuals with rare diseases;
 - b. The impact of health insurance coverage, cost sharing, tiers, or other utilization management procedures on access to health care and other necessary services; and
 - c. The impact of providing coverage under the state program for medical assistance services for approved health care services and medications for rare diseases.
3. Publish a list of existing publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases on the Council's webpage.
4. Submit annually by October 1 a report to the Governor and the General Assembly for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The annual report shall (i) describe the activities and recommendations of the Council and (ii) describe the status of funding available to the Council, including information regarding any grants applied for and received by the Council.
5. Apply for, accept, and expend gifts, grants, and donations from public or private sources to enable the Council to better carry out its objectives.

2021, Sp. Sess. I, c. [303](#).

§ 32.1-73.16. Membership; terms; quorum; meetings; staffing.

A. The Council shall have a total membership of 21 members that shall consist of 18 nonlegislative citizen members and three ex officio members. The Governor shall appoint a chairman and vice-chairman who shall be residents of the Commonwealth and shall not be employed by any federal or state government. Nonlegislative citizen members shall be appointed by the Governor and shall include, in addition to the chairman and the vice-chairman, one representative from an academic research institution in the Commonwealth that receives any grant funding for rare disease research; one geneticist licensed and currently practicing in the Commonwealth; one registered nurse or advanced practice registered nurse licensed and currently practicing in the Commonwealth, with experience in

treating rare diseases; two physicians with expertise in rare diseases who are licensed and currently practicing medicine in the Commonwealth; one hospital administrator, or his designee, from a hospital in the Commonwealth that provides care to persons diagnosed with rare diseases; two persons who are 18 years of age or older who have been diagnosed with a rare disease; two caregivers of persons with a rare disease; two representatives of rare disease patient organizations operating in the Commonwealth; one licensed pharmacist with experience with drugs used to treat rare diseases; one representative from the biopharmaceutical industry; one representative from health plan companies; and one member from the scientific community who is engaged in rare disease research, which may include a medical researcher with experience conducting research on rare diseases. The Commissioner of Health, the Director of the Department of Medical Assistance Services, and the Superintendent of Public Instruction, or their designees, shall serve ex officio with nonvoting privileges. Ex officio members of the Council shall serve terms coincident with their terms of office.

Nonlegislative citizen members of the Council shall be citizens of the Commonwealth. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of three years.

Ex officio members of the Council shall serve terms coincident with their terms of office. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years.

B. The Council shall meet quarterly and the chairman and vice-chairman shall establish a meeting schedule on an annual basis. A majority of the members shall constitute a quorum.

C. Members of the Council shall serve without compensation or reimbursement.

D. The Department of Health shall provide staff support to the Council. All agencies of the Commonwealth shall provide assistance to the Council, upon request.

2021, Sp. Sess. I, c. [303](#).

§ 32.1-73.17. Rare Disease Council Fund.

There is hereby created in the state treasury a special nonreverting fund to be known as the Rare Disease Council Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the Comptroller. All funds appropriated for such purpose and any gifts, grants, donations, and other funds received on its behalf shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purpose of (i) funding research related to rare diseases and the development of new treatments for rare diseases and support for persons with rare diseases in the Commonwealth and (ii) supporting the work of the Council. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner of Health.

2021, Sp. Sess. I, c. [303](#).

Article 20. Renal Disease Council.

§ 32.1-73.18. Renal Disease Council; purpose.

There is hereby created in the executive branch of state government the Renal Disease Council (the Council) for the purpose of (i) advising the Governor and the General Assembly on the needs of individuals with renal disease in the Commonwealth; (ii) identifying challenges that such individuals face and making recommendations for the improvement of the Commonwealth's kidney care system, particularly related to care coordination and prevention; (iii) funding research related to renal disease (iv) funding supports for persons with renal disease in the Commonwealth; and (v) developing program to educate medical professionals and the public about renal disease.

2022, c. [717](#).

§ 32.1-73.19. Powers and duties of the Council.

The Council shall have the power and duty to:

1. Within the first year, hold public hearings and make inquiries of and solicit comments from the public to assist the Council in understanding the scope of the challenges related to renal disease in the Commonwealth and the impact of renal disease on individuals in the Commonwealth.
2. Conduct research and consult with experts to develop policy recommendations related to:
 - a. Improving access to health care and other services for individuals with renal disease, including access to health insurance, specialists, health care services, and other necessary services for individuals with renal disease;
 - b. The impact of health insurance coverage, cost-sharing, tiers, or other utilization management procedures on access to health care and other necessary services; and
 - c. The impact of providing coverage under the state program for medical assistance services for approved health care services and medications for renal disease.
3. Publish a list of existing publicly accessible resources on research, diagnosis, treatment, and education relating to renal disease on the Council's webpage.
4. Submit annually by October 1 a report to the Governor and the General Assembly for publication as report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The annual report shall (i) describe the activities and recommendations of the Council and (ii) describe the status of funding available to the Council, including information regarding any grants applied for and received by the Council.
5. Apply for, accept, and expend gifts, grants, and donations from public or private sources to enable the Council to better carry out its objectives.

2022, c. [717](#).

§ 32.1-73.20. Membership; terms; quorum; meetings; staffing.

A. The Council shall have a total membership of 21 members that shall consist of 18 nonlegislative citizen members and three ex officio members. The Governor shall appoint a chairman and vice-

chairman who shall be residents of the Commonwealth and shall not be employed by any federal or state government. Nonlegislative citizen members shall be appointed by the Governor and shall include in addition to the chairman and the vice-chairman, one representative from an academic research institution in the Commonwealth that receives any grant funding for renal disease research; one registered nurse or advanced practice registered nurse licensed and currently practicing in the Commonwealth with experience in treating renal disease; two physicians with expertise in renal disease who are licensed and currently practicing medicine in the Commonwealth; one hospital administrator or his designee, from a hospital in the Commonwealth that provides care to persons diagnosed with renal disease; one person who is a dialysis social worker; two persons who are 18 years of age or older who have been diagnosed with a renal disease; two caregivers of persons with renal disease; two representatives of renal disease patient organizations operating in the Commonwealth; one licensed pharmacist with experience with drugs used to treat renal disease; one representative from the biopharmaceutical industry; one representative from health plan companies; and one member from the scientific community who is engaged in renal disease research, which may include a medical researcher with experience conducting research on renal disease. The Commissioner of Health, the Director of the Department of Medical Assistance Services, and the Director of the Department of Health Professions, or their designees, shall serve ex officio with nonvoting privileges.

Nonlegislative citizen members of the Council shall be citizens of the Commonwealth. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years.

Ex officio members of the Council shall serve terms coincident with their terms of office.

Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

B. The Council shall meet quarterly and the chairman and vice-chairman shall establish a meeting schedule on an annual basis. A majority of the members shall constitute a quorum.

C. Members of the Council shall serve without compensation or reimbursement.

D. The Department of Health shall provide staff support to the Council. All agencies of the Commonwealth shall provide assistance to the Council, upon request.

2022, c. [717](#).

Article 21. Adult Wellness Screening.

§ 32.1-73.21. Adult wellness screening for sickle cell disease or the sickle cell trait.

In order to prevent disability or death, every adult resident of the Commonwealth may be offered screening tests for sickle cell disease or sickle cell trait, with an emphasis on individuals of reproductive age and individuals who are unaware of their sickle cell trait status.

The health care professional in charge of the adult's annual health examination may cause such tests to be performed, and if performed, shall provide education and appropriate counseling regarding the test results.

The program for screening adults for sickle cell disease or the sickle cell trait may be conducted in addition to the programs provided for in Article 8 (§ [32.1-68](#) et seq.).

2024, c. [182](#).

§ 32.1-73.21:1. Sickle Cell Trait Awareness and Education Program.

The Department shall establish and administer the Sickle Cell Trait Awareness and Education Program (the Program) to (i) conduct public awareness campaigns; (ii) provide educational resources; (iii) provide training to professionals, including health care providers, genetic counselors, school nurses, and educators; (iv) conduct community outreach; and (v) coordinate with existing infrastructure for screening and treatment of sickle cell trait and sickle cell disease. The Program shall provide information on screening services conducted pursuant to §§ [32.1-68](#) and [32.1-73.21](#) and newborn screening conducted pursuant to Article 7 (§ [32.1-65](#) et seq.).

2026, c. [846](#).

Article 22. Statewide Sickle Cell Disease Registry.

§ 32.1-73.22. Information from hospitals, clinics, certain laboratories, and physicians supplied Commissioner; statewide sickle cell disease registry.

A. Each hospital, clinic, and independent pathology laboratory shall make available to the Commissioner or his agents information on patients having sickle cell disease. A physician shall report information on patients having sickle cell disease unless he has determined that a hospital, clinic, or independent pathology laboratory has reported the information. Such information shall include the name, address, sex, race, diagnosis, trait status, newborn screening data, and any other pertinent identifying information regarding each such patient. Each hospital, clinic, independent pathology laboratory, or physician shall provide other available clinical information as defined by the Board.

B. From such information the Commissioner shall establish and maintain a statewide sickle cell disease registry. The purpose of the statewide sickle cell disease registry shall include:

1. Determining means of improving the diagnosis and treatment of sickle cell disease patients.
2. Determining the need for and means of providing better long-term, follow-up care to sickle cell disease patients.
3. Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of sickle cell disease in Virginia.
4. Improving rehabilitative programs for sickle cell disease patients.
5. Assisting in the training of hospital personnel.
6. Determining other needs of sickle cell disease patients and health personnel.

2024, c. [437](#).

§ 32.1-73.23. Collection of sickle cell disease case information by the Commissioner.

A. Using such funds as may be appropriated therefor, the Commissioner or his designee may perform on-site data collection of the records of patients having sickle cell disease at those consenting hospitals, clinics, independent pathology laboratories, and physician offices required to report information on

such patients pursuant to the reporting requirements of § 32.1-73.22 in order to ensure the completeness and accuracy of the statewide sickle cell disease registry.

B. The selection criteria for determining which consenting hospitals, clinics, independent pathology laboratories, and physician offices may be subject to on-site data collection under the provisions of this section shall include (i) the expected annual number of sickle cell disease case reports from each such facility, (ii) the historical completeness and accuracy of reporting rates of each facility under consideration, and (iii) whether the facility maintains its own sickle cell disease registry.

C. The Board shall promulgate regulations necessary to implement the provisions of this section.

2024, c. 437.

§ 32.1-73.24. Confidential nature of information supplied; publication; reciprocal data-sharing agreements.

A. The Commissioner and all persons to whom information is submitted in accordance with § 32.1-73.24 shall keep such information confidential. Except as authorized by the Commissioner in accordance with the provisions of § 32.1-41, no release of any such information shall be made except in the form of statistical or other studies that do not identify individual cases.

B. The Commissioner may enter into reciprocal data-sharing agreements with other sickle cell disease registries for the exchange of information. Upon the provision of satisfactory assurances for the preservation of the confidentiality of such information, patient-identifying information may be exchanged with other sickle cell disease registries that have entered into reciprocal data-sharing agreements with the Commissioner.

2024, c. 437.

§ 32.1-73.25. Penalties for unauthorized use of statewide sickle cell disease registry.

In addition to the remedies provided in § 32.1-27, any person who uses, discloses, or releases data maintained in the statewide sickle cell disease registry in violation of § 32.1-73.24 shall be subject, in the discretion of the court, to a civil penalty not to exceed \$25,000 for each violation, which shall be paid to the general fund.

2024, c. 437.

§ 32.1-73.26. Notification of sickle cell disease patients of statewide sickle cell disease registry reporting.

A. Any physician diagnosing sickle cell disease shall, at such time and in such manner as considered appropriate by such physician, notify each patient whose name and record abstract is required to be reported to the statewide sickle cell disease registry pursuant to § 32.1-73.22 that personal identifying information about him has been included in the registry as required by law. Any physician required to notify a patient that personal identifying information about him has been included in the sickle cell disease registry may, when, in the opinion of the physician, such notice would be injurious to the patient's health or well-being, provide the required notice to the patient's authorized representative or next of kin in lieu of notifying the patient.

B. Upon request to the statewide sickle cell disease registry, the patient whose personal identifying information has been submitted to such registry shall have a right to know the identity of the reporter of his information to such registry. A patient diagnosed with sickle cell disease may self-report information to the statewide sickle cell disease registry. A patient diagnosed with sickle cell disease shall have the right to opt out of having his data reported to the statewide sickle cell disease registry.

2024, c. [437](#).

§ 32.1-73.27. Annual report; sickle cell disease registry.

The Commissioner shall submit to the Governor and the General Assembly, by November 1 of each year, a report of the information obtained under this article.

2024, c. [437](#).

Article 22.1. Sickle Cell Coordinated Access Network.

§ 32.1-73.27:1. (Effective July 1, 2027) Sickle Cell Coordinated Access Network; purpose.

A. As used in this section:

"Network" means the Sickle Cell Coordinated Access Network established in this article.

"Sickle cell specialist" means a health care professional who specializes in the treatment of sickle cell trait and sickle cell disease.

B. The Commissioner shall establish and maintain the Sickle Cell Coordinated Access Network, in collaboration with and under the Virginia Commonwealth University Health Systems Authority, for the purpose of providing health care providers in the Commonwealth with real-time consultation and support from sickle cell specialists.

C. The Network shall ensure that sickle cell specialists are available for telehealth consultation with health care providers for extended coverage. Sickle cell specialists participating in the Network shall provide (i) guidance on pain management, (ii) consultation on treatment protocols, and (iii) coordination of care to health care providers.

2026, cc. [838](#), [839](#).

Article 23. Women's Menstrual Health Program.

§ 32.1-73.28. Women's Menstrual Health Program.

A. For the purposes of this section:

"Endometriosis" means a systemic disease generally occurring in menstruating individuals, which may also occur in premenarchal and postmenopausal individuals.

"Menstrual disorder" means any menstruation-related disorder or menstruation-related condition and includes endometriosis and polycystic ovary syndrome.

B. The Commissioner shall establish within the Department the Women's Menstrual Health Program to identify and assist patients who have displayed symptoms related to menstrual disorders.

C. The Department shall, in accordance with evidence-based industry best practices, guidelines, and screening tools, as recommended by the American College of Obstetricians and Gynecologists or another nationally recognized body as may be designated by the Commissioner:

1. Provide education and training to health care providers, hospital staff who encounter patients in emergency situations, and the public concerning menstrual health, menstrual health screening, and menstrual health care; and
2. Provide information and resources on the Department's website for health care providers and patients, which shall include:
 - a. Evidence-based clinical practice guidelines for health care providers for the screening, referral, treatment, and follow-up care of patients who have displayed symptoms related to menstrual disorder and
 - b. Educational materials for health care providers and the public concerning menstrual disorders.

2025, c. 694.

§ 32.1-73.28:1. (Effective January 1, 2027) Menstrual products ingredient labeling; civil penalty

A. As used in this section:

"Confidential substance" means any element or substance that a manufacturer has added to a menstrual product that serves a technical or functional purpose in the finished menstrual product and:

1. For which a claim has been approved by the U.S. Environmental Protection Agency for inclusion on the confidential portion of the Toxic Substances Control Act Chemical Substance Inventory, established pursuant to 15 U.S.C. § 2607(b) and 40 C.F.R. Part 710;
2. For which the manufacturer of the menstrual products or the supplier of the substance claims protection under the federal Defend Trade Secrets Act of 2016 (18 U.S.C. § 1836 et seq.); or
3. That is generally recognized as safe by the U.S. Food and Drug Administration pursuant to 21 C.F.R. 170.30.

"Ingredient" means any intentionally added substance present in a menstrual product that serves a technical or functional purpose in the finished product, provided that the substance or the combination of substances is not considered a confidential substance.

"Label" means a display of written, printed, or graphic material on or affixed to a container in which the menstrual products are distributed.

"Menstrual product" means a disposable or reusable product manufactured for the purpose of catching menstruation and vaginal discharge, including a tampon, sanitary pad, disc, menstrual cup, and menstrual underwear.

"Package or box containing menstrual products" does not include packaging used exclusively for shipping purposes.

B. Each package or box containing menstrual products manufactured for sale or distribution within the Commonwealth shall contain a label of all ingredients that are included within such menstrual products, with such ingredients listed in descending order of predominance. The label shall be displayed by the manufacturer in a manner that is visible and easy for the consumer to understand. A manufacturer that changes, adds, or removes an ingredient of a menstrual product shall make changes to the label required pursuant to this subsection reflecting such change, addition, or removal within 12 months of such change, addition, or removal. The provisions of this subsection shall not restrict the continued sale of menstrual products manufactured before January 1, 2027.

C. A manufacturer of menstrual products shall post on its website (i) the label information required to be disclosed on each package or box containing menstrual products pursuant to subsection B and (ii) information regarding any change to the label on a menstrual product required pursuant to subsection B after changing, adding, or removing an ingredient within six months of such change, addition, or removal. The manufacturer may use technologies, including a digital link, to communicate information pursuant to this section.

D. No manufacturer of menstrual products sold within the Commonwealth shall be required under this section to disclose a confidential substance on a package or box or on its website. If a manufacturer declines to disclose a confidential substance on a package or box containing menstrual products or on its website in order to protect the identity of such confidential substance, such manufacturer shall include such confidential substance by its common name with the label information required to be disclosed on each package or box containing menstrual products pursuant to subsection B.

E. Any violation of this section shall constitute a prohibited practice under § 59.1-200 and shall be subject to the enforcement provisions of the Virginia Consumer Protection Act (§ 59.1-196 et seq.). 2026, c. 249.

Article 24. Postpartum Depression Education Act.

§ 32.1-73.29. Public awareness campaign; Department authorized to seek funding.

A. The Department, in collaboration with the Department of Behavioral Health and Developmental Services, shall develop and implement a statewide public awareness campaign on perinatal and postpartum depression. Such campaign shall:

1. Increase awareness about the symptoms, risk factors, and treatment options for perinatal and postpartum depression;
2. Provide culturally appropriate and accessible materials for diverse populations;
3. Provide information to health care providers, birthing individuals, families, and community organizations;
4. Utilize multiple platforms, including digital media, print materials, and community outreach programs, to maximize public engagement; and
5. Highlight the importance of seeking early treatment for and reducing the stigma associated with perinatal and postpartum depression.

B. The Department may seek and accept funding from any public or private entities to implement the provisions of this article.

2025, c. [700](#).

§ 32.1-73.30. Development of educational materials and resources.

A. The Department shall create and distribute educational materials on perinatal and postpartum depression. Such materials shall include:

1. Fact sheets on symptoms, causes, and available treatment options;
2. Contact information for local, state, and national resources, including crisis hotlines, counseling services, and support groups;
3. Guidance for health care providers on screening, diagnosing, and managing perinatal and postpartum depression; and
4. Information on the impact of untreated perinatal and postpartum depression on maternal and infant health outcomes.

B. The Department shall distribute materials prepared pursuant to subsection A to:

1. Health care providers, including obstetricians, midwives, pediatricians, and primary care physicians
2. Hospitals, birthing centers, and clinics;
3. Community organizations, including faith-based groups and nonprofit organizations; and
4. Public health offices and other relevant government agencies.

2025, c. [700](#).

§ 32.1-73.31. Online resource hub.

The Department shall develop and maintain an online resource hub that provides:

1. Up-to-date information on perinatal and postpartum depression;
2. A directory of mental health providers specializing in perinatal and postpartum care;
3. Information on available support groups, counseling services, and treatment options; and
4. A platform for individuals and families to share experiences and connect with community resources

2025, c. [700](#).

§ 32.1-73.32. Annual report.

A. The Department shall submit an annual report to the Governor and the General Assembly that includes:

1. Metrics on public engagement with the programs implemented pursuant to this article;
2. Feedback from health care providers, community organizations, and individuals served by programs implemented pursuant to this article;

3. Progress in reducing stigma and increasing early detection and treatment of perinatal and postpartum depression; and
 4. Recommendations for improving or expanding programs implemented pursuant to this article.
- B. The Department shall publish the annual report prepared pursuant to subsection A on its website. 2025, c. 700.

Article 25. Severe Maternal Morbidity Surveillance and Review Program.

§ 32.1-73.33. (Effective September 1, 2026) Severe Maternal Morbidity Surveillance and Review Program.

A. For the purposes of this section:

"Severe maternal morbidity" means unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman's health.

"SMM Program" means the Severe Maternal Morbidity Surveillance and Review Program established pursuant to this article.

B. The Department shall:

1. Establish the Severe Maternal Morbidity Surveillance and Review Program for the purpose of identifying, analyzing, and reviewing instances of severe maternal morbidity;
2. Develop a reporting system for hospitals and freestanding birthing centers to report findings and recommendations;
3. Develop a severe maternal morbidity surveillance case definition aligned with evidence-based practice and reflecting stakeholder subject matter expertise; and
4. Develop a model protocol for the development and implementation of severe maternal mortality advisory boards established pursuant to subsection C. Such model protocol shall include relevant procedures for conducting reviews of severe maternal morbidity.

C. Each hospital and freestanding birthing center shall participate in the SMM Program and shall:

1. Establish an advisory board to review severe maternal morbidity cases. Such advisory board shall consist of a multidisciplinary group of health care providers, experts in maternal care, and community members, including:
 - a. At least one representative from a community-based organization primarily serving minority populations with high rates of maternal mortality or morbidity;
 - b. At least one community-based doula or midwife with experience in providing perinatal support; and
 - c. Other relevant community members, as deemed appropriate by the hospital or freestanding birth center.
2. Review all severe maternal morbidity events using the severe maternal morbidity surveillance case definition;

3. Identify the drivers, risk factors, and causes of severe maternal morbidity;
4. Engage in quality improvement efforts regarding severe maternal morbidity based on the reviews;
5. Determine whether severe maternal morbidity events were potentially preventable;
6. Make recommendations to reduce the prevalence of severe maternal morbidity in the Commonwealth and
7. Report its findings and recommendations to the Department on an annual basis at a time and through a reporting system specified by the Department.

D. The Department shall analyze reports submitted pursuant to subdivision C 7 and incorporate recommendations as part of the annual report released by the SMM Program. The SMM Program shall also work collaboratively with the Maternal Mortality Review Team established pursuant to § 32.1-283 to address shared risk and protective factors for both severe maternal morbidity and maternal mortality.

E. The Department shall annually compile statewide trends of severe maternal morbidity and publish such trends on its website. Any statistical compilations relating to severe maternal morbidity shall comply with the provisions of § 32.1-127.1:03 and the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.) and shall not contain any personal identifying information.

F. Upon the request of the Department, made after the conclusion of any law-enforcement investigation or prosecution, the Department or its designee may inspect and copy information and records regarding a severe maternal morbidity event. Information, records, or reports maintained by any attorney for the Commonwealth shall be made available for inspection and copying by the Department or its designee pursuant to procedures that shall be developed by the Department and the Commonwealth's Attorney Services Council established by § 2.2-2617. Any presentence report prepared pursuant to § 19.2-299 for any person convicted of a crime that led to a severe maternal morbidity event shall be made available for inspection and copying by the Department or its designee. In addition, the Department or its designee may inspect and copy from any health care provider or hospital system in the Commonwealth on behalf of the SMM Program, (i) without obtaining consent, subject to any limitations on disclosure under applicable federal and state law, the health and mental health records of the woman and those prenatal medical records relating to any child born to the woman and (ii) upon obtaining consent, from each adult regarding his records.

G. All information and records obtained or created by the SMM Program or on behalf of the SMM Program regarding a review shall be confidential and excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the SMM Program only in the exercise of its proper purpose and function and shall not be disclosed. In preparing information and records for review by the SMM Program, the Department shall remove any individually identifiable information or information identifying a health care provider, as those terms are defined in 45 C.F.R. § 160.103. Such information shall not be subject to subpoena, subpoena duces tecum, or discovery, be admissible in any civil or criminal proceeding, or be used as evidence in any disciplinary proceeding or regulatory or licensure action of the Department of Health Professions or any health regulatory board. If available from other sources, however, such

information and records shall not be immune from subpoena, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the SMM Program during a severe maternal morbidity review. The findings of the SMM Program may be disclosed or published in statistical or other form but shall not identify any individual. Upon conclusion of the severe maternal morbidity review, all information and records concerning the case shall be shredded or otherwise destroyed by the Department in order to ensure confidentiality.

All portions of meetings in which individual severe morbidity events are discussed by the SMM Program shall be closed pursuant to subdivision A 21 of § 2.2-3711. In addition to the requirements of § 2.2-3711, all SMM Program members and other persons attending closed SMM Program meetings, including any persons presenting information or records on specific severe maternal morbidity events to the SMM Program during closed meetings, shall execute a sworn statement to (i) honor the confidentiality of the information, records, discussions, and opinions disclosed during meetings at which the SMM Program reviews a specific severe maternal morbidity event and (ii) not use any such information, records, discussions, or opinions disclosed during meetings at which the SMM Program reviews a specific severe maternal morbidity event for any purpose other than the exercise of the proper purpose and function of the SMM Program. Violations of this subsection are punishable as a Class 3 misdemeanor.

H. The Board shall promulgate regulations as necessary to implement the SMM Program.

2026, c. 842.

9/29/20

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For Developers

The Virginia Law website data is available via a web service. 

