UNANNOTATED

CHAPTER 24
Health and Safety

ARTICLE 1
Public Health

24-1-1. Short title.

Chapter 24, Article 1 NMSA 1978 may be cited as the "Public Health Act".

History: 1953 Comp., § 12-34-1, enacted by Laws 1973, ch. 359, § 1; 2004, ch. 44, § 1; 2004, ch. 50, § 1.

24-1-2. Definitions.

As used in the Public Health Act:

A. "condition of public health importance" means an infection, a disease, a syndrome, a symptom, an injury or other threat that is identifiable on an individual or community level and can reasonably be expected to lead to adverse health effects in the community;

B. "crisis triage center" means a health facility that:

(1) is licensed by the department of health; and

(2) provides stabilization of behavioral health crises and may include residential and nonresidential stabilization;

C. "department" means:

(1) the department of health; or

(2) the children, youth and families department as to residential treatment centers that serve persons up to twenty-one years of age, community mental health centers that serve only persons up to twenty-one years of age, day treatment centers that serve persons up to twenty-one years of age, shelter care homes and those outpatient facilities that are also community-based behavioral health facilities serving only persons up to twenty-one years of age;

D. "director" means the secretary;

E. "health care provider" means a person licensed to provide health care in the ordinary course of business, except as otherwise defined in the Public Health Act;

F. "health facility" means a public hospital, profit or nonprofit private hospital, general or special hospital, outpatient facility, crisis triage center, freestanding birth center, adult daycare facility, nursing home, intermediate care facility, assisted living facility, boarding home not under the control of an institution of higher learning, child care facility, shelter care home, diagnostic and treatment center, rehabilitation center, infirmary, community mental health center that serves both children and adults or adults only, residential treatment center that serves persons up to twenty-one years of age, community mental health center that serves only persons up to twenty-one years of age and day treatment center that serves persons up to twenty-one years of age or a health service organization operating as a freestanding hospice or a home health agency. The designation of these entities as health facilities is only for the purposes of definition in the Public Health Act and does not imply that a freestanding hospice or a home health agency is considered a health facility for the purposes of other provisions of state or federal laws. "Health facility" also includes those facilities that, by federal regulation, must be licensed by the state to obtain or maintain full or partial, permanent or temporary federal funding. It does not include the offices and treatment rooms of licensed private practitioners;

G. "screening" means a preliminary procedure, including a test or examination, that:

(1) may require further investigation; and

(2) can identify individuals with unrecognized health risk factors or asymptomatic disease conditions in populations;

H. "secretary" means:

(1) the secretary of health;

(2) the secretary of children, youth and families as to residential treatment centers that serve persons up to twenty-one years of age, community mental health centers that serve only persons up to twenty-one years of age, day treatment centers that serve persons up to twenty-one years of age, shelter care homes and those outpatient facilities that are also community-based behavioral health facilities serving only persons up to twenty-one years of age; or

(3) the secretary of early childhood education and care for child care facilities; and

I. "test" means any diagnostic or investigative analysis or medical procedure that determines the presence of, absence of or exposure to a condition of public health importance or its precursor in an individual.

History: 1953 Comp., § 12-34-2, enacted by Laws 1973, ch. 359, § 2; 1977, ch. 253, § 39; 1979, ch. 25, § 1; 1981, ch. 171, § 10; 1983, ch. 112, § 1; 1987, ch. 27, § 1; 1996, ch. 35, § 1; 1999, ch. 165, § 1; 2003, ch. 284, § 1; 2007, ch. 325, § 6; 2007, ch. 326, § 1; 2015, ch. 61, § 1; 2015, ch. 153, § 1; 2017, ch. 87, § 4; 2018, ch. 34, § 1; 2022, ch. 30, § 5.

24-1-3. Powers and authority of department.

The department has authority to:

A. receive such grants, subsidies, donations, allotments or bequests as may be offered to the state by the federal government or any department thereof or by any public or private foundation or individuals;

B. supervise the health and hygiene of the people of the state and identify ways to evaluate and address community health problems;

C. investigate, control and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health;

D. establish, maintain and enforce isolation and quarantine;

E. close any public place and forbid gatherings of people when necessary for the protection of the public health;

F. respond to public health emergencies and assist communities in recovery;

G. establish programs and adopt rules to prevent infant mortality, birth defects and morbidity;

H. prescribe the duties of public health nurses and school nurses;

I. provide educational programs and disseminate information on public health;

J. maintain and enforce rules for the licensure of health facilities;

K. ensure the quality and accessibility of health care services and the provision of health care when health care is otherwise unavailable;

L. ensure a competent public health workforce;

M. bring action in court for the enforcement of health laws and rules and orders issued by the department;

N. enter into agreements with other states to carry out the powers and duties of the department;

O. cooperate and enter into contracts or agreements with the federal government or any other person to carry out the powers and duties of the department;

P. cooperate and enter into contracts or agreements with Native American nations, tribes and pueblos and off-reservation groups to coordinate the provision of essential public health services and functions;

Q. maintain and enforce rules for the control of conditions of public health importance;

R. maintain and enforce rules for immunization against conditions of public health importance;

S. maintain and enforce such rules as may be necessary to carry out the provisions of the Public Health Act and to publish the rules;

T. supervise state public health activities, operate a dental public health program and operate state laboratories for the investigation of public health matters;

U. sue and, with the consent of the legislature, be sued;

V. regulate the practice of midwifery;

W. administer legislation enacted pursuant to Title 6 of the Public Health Service Act, as amended and supplemented;

X. inspect such premises or vehicles as necessary to ascertain the existence or nonexistence of conditions dangerous to public health or safety;

Y. request and inspect, while maintaining federal and state confidentiality requirements, copies of:

(1) medical and clinical records reasonably required for the department's quality assurance and quality improvement activities; and

(2) all medical and clinical records pertaining to the individual whose death is the subject of inquiry by the department's mortality review activities; and

Z. do all other things necessary to carry out its duties.

History: 1953 Comp., § 12-34-3, enacted by Laws 1973, ch. 359, § 3; 1975, ch. 183, § 2; 2001, ch. 119, § 2; 2017, ch. 87, § 5.

24-1-4. Creation of health regions; appointment of health officers; powers and duties of health officers.

A. The director shall establish health regions and may modify and create new health regions as the director deems necessary.

B. A regional health officer shall provide medical oversight to school nurses in the regional health officer's region. A school nurse shall make reports relating to public health as the regional health officer in the school nurse's region requires.

C. As used in this section, "medical oversight" means advice and direction that is provided by a regional health officer or under the direction of a regional health officer to a school nurse, or a school nurse's designee, who performs nursing activities in a school setting.

History: 1953 Comp., § 12-34-4, enacted by Laws 1973, ch. 359, § 4; 2017, ch. 87, § 6.

24-1-4.1. Certified nurse-midwives; prescriptive, distributing and administering authority.

A. Certified nurse-midwives who have fulfilled requirements for prescriptive authority may prescribe in accordance with rules, regulations, guidelines and formularies for individual certified nurse-midwives promulgated by the department of health.

B. As used in this section, "prescriptive authority" means the ability of the certified nurse-midwife to practice independently, serve as a primary care provider and as necessary collaborate with licensed medical doctors or osteopathic physicians. Certified nurse-midwives who have fulfilled requirements for prescribing drugs may prescribe, distribute and administer to their patients dangerous drugs, including controlled substances included in Schedules II through V [30-31-7 to 30-31-10 NMSA 1978] of the Controlled Substances Act [Chapter 30 NMSA 1978], that have been prepared, packaged or fabricated by a licensed pharmacist or doses of drugs that have been prepackaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act [Chapter 61, Article 11 NMSA 1978] and New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978].

History: Laws 1997, ch. 253, § 1.

24-1-5. Licensure of health facilities; hearings; appeals.

A. A health facility shall not be operated without a license issued by the department. If a health facility is found to be operating without a license, in order to protect human health or safety, the secretary may issue a cease-and-desist order. The health facility may request a hearing that shall be held in the manner provided in this section. The department may also proceed pursuant to the Health Facility Receivership Act [Chapter 24A, Article 2 NMSA 1978].

B. The department is authorized to make inspections and investigations and to prescribe rules it deems necessary or desirable to promote the health, safety and welfare of persons using health facilities.

C. Except as provided in Subsection F of this section, upon receipt of an application for a license to operate a health facility, the department shall promptly inspect the health facility to determine if it is in compliance with all rules of the department. Applications for hospital licenses shall include evidence that the bylaws or rules of the hospital apply equally to osteopathic and medical physicians. The department shall consolidate the applications and inspections for a hospital that also operates as a hospital-based primary care clinic.

D. Upon inspection of a health facility, if the department finds a violation of its rules, the department may deny the application for a license, whether initial or renewal, or it may issue a temporary license. A temporary license shall not be issued for a period exceeding one hundred twenty days, nor shall more than two consecutive temporary licenses be issued.

E. A one-year nontransferable license shall be issued to any health facility complying with all rules of the department. The license shall be renewable for successive one-year periods, upon filing of a renewal application, if the department is satisfied that the health facility is in compliance with all rules of the department or, if not in compliance with a rule, has been granted a waiver or variance of that rule by the department pursuant to procedures, conditions and guidelines adopted by rule of the department. Licenses shall be posted in a conspicuous place on the licensed premises, except that child care centers that receive no state or federal funds may apply for and receive from the department a waiver from the requirement that a license be posted or kept on the licensed premises.

F. A health facility that has been inspected and licensed by the department, that has received certification for participation in federal reimbursement programs and that has been fully accredited by a national accrediting organization approved by the federal centers for medicare and medicaid services or the department shall be granted a license renewal based on that accreditation. A freestanding birth center that has been inspected and licensed by the department and is accredited by the commission for accreditation of birth centers or its successor accreditation body shall be granted a license renewal based on that accreditation. Health facilities receiving less than full accreditation by an approved accrediting body may be granted a license renewal based on that accreditation. License renewals shall be issued upon application submitted by the health facility upon forms prescribed by the department. This subsection does not limit in any way the department's various duties and responsibilities under other provisions of the Public Health Act or under any other subsection of this section, including any of the department's responsibilities for the health and safety of the public.

G. The department may charge a reasonable fee not to exceed twelve dollars ($12.00) per bed for an inpatient health facility or three hundred dollars ($300) for any

other health facility for each license application, whether initial or renewal, of an annual license or the second consecutive issuance of a temporary license. Fees collected shall not be refundable. All fees collected pursuant to licensure applications shall be deposited with the state treasurer for credit in a designated department recurring account for use in health facility licensure and certification operations.

H. The department may revoke or suspend the license of a health facility or may impose on a health facility an intermediate sanction and a civil monetary penalty provided in Section 24-1-5.2 NMSA 1978 after notice and an opportunity for a hearing before a hearing officer designated by the department to hear the matter and, except for child care centers and facilities, may proceed pursuant to the Health Facility Receivership Act upon a determination that the health facility is not in compliance with any rule of the department. If immediate action is required to protect human health and safety, the secretary may suspend a license or impose an intermediate sanction pending a hearing, provided the hearing is held within five working days of the suspension or imposition of the sanction, unless waived by the licensee, and, except for child care centers and facilities, may proceed ex parte pursuant to the Health Facility Receivership Act.

I. The department shall schedule a hearing pursuant to Subsection H of this section if the department receives a request for a hearing from a licensee:

(1) within ten working days after receipt by the licensee of notice of suspension, revocation, imposition of an intermediate sanction or civil monetary penalty or denial of an initial or renewal application;

(2) within four working days after receipt by the licensee of an emergency suspension order or emergency intermediate sanction imposition and notice of hearing if the licensee wishes to waive the early hearing scheduled and request a hearing at a later date; or

(3) within five working days after receipt of a cease-and-desist order.

The department shall also provide timely notice to the licensee of the date, time and place of the hearing, identity of the hearing officer, subject matter of the hearing and alleged violations.

J. A hearing held pursuant to provisions of this section shall be conducted in accordance with adjudicatory hearing rules and procedures adopted by rule of the department. The licensee has the right to be represented by counsel, to present all relevant evidence by means of witnesses and books, papers, documents, records, files and other evidence and to examine all opposing witnesses who appear on any matter relevant to the issues. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum prior to or after the commencement of the hearing to compel discovery and the attendance of witnesses and the production of relevant books, papers, documents, records, files and other

evidence. Documents or records pertaining to abuse, neglect or exploitation of a resident, client or patient of a health facility or other documents, records or files in the custody of the human services department [health care authority department] or the office of the state long-term care ombudsman at the aging and long-term services department that are relevant to the alleged violations are discoverable and admissible as evidence in any hearing.

K. Any party may appeal the final decision of the department pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

L. A complaint about a health facility received by the department pursuant to this section shall be promptly investigated and appropriate action shall be taken if substantiated. The department shall develop a health facilities protocol in conjunction with the human services department [health care authority department], the protective services division of the children, youth and families department, the office of the state long-term care ombudsman and other appropriate agencies to ensure the health, safety and rights of individuals in health facilities. The health facilities protocol shall require:

(1) cross-reference among agencies pursuant to this subsection of an allegation of abuse, neglect or exploitation;

(2) an investigation, within the strict priority time frames established by each protocol member's rules, of an allegation or referral of abuse, neglect or exploitation after the department has made a good cause determination that abuse, neglect or exploitation occurred;

(3) an agency to share its investigative information and findings with other agencies, unless otherwise prohibited by law; and

(4) require the receiving agency to accept the information provided pursuant to Paragraph (3) of this subsection as potential evidence to initiate and conduct investigations.

M. A complaint received by the department pursuant to this section shall not be disclosed publicly in a manner as to identify any individuals or health facilities if upon investigation the complaint is unsubstantiated.

N. The name and information regarding the person making a complaint pursuant to this section shall not be disclosed absent the consent of the informant or a court order.

O. Notwithstanding any other provision of this section, when there are reasonable grounds to believe that a child is in imminent danger of abuse or neglect while in the care of a child care facility, whether or not licensed, or upon the receipt of a report pursuant to Section 32A-4-3 NMSA 1978, the department shall consult with the owner or operator of the child care facility. Upon a finding of probable cause, the department shall give the owner or operator notice of its intent to suspend operation of the child

care facility and provide an opportunity for a hearing to be held within three working days, unless waived by the owner or operator. Within seven working days from the day of notice, the secretary shall make a decision, and, if it is determined that any child is in imminent danger of abuse or neglect in the child care facility, the secretary may suspend operation of the child care facility for a period not in excess of fifteen days. Prior to the date of the hearing, the department shall make a reasonable effort to notify the parents of children in the child care facility of the notice and opportunity for hearing given to the owner or operator.

P. Nothing contained in this section or in the Public Health Act shall authorize either the secretary or the department to make any inspection or investigation or to prescribe any rules concerning group homes as defined in Section 9-8-13 NMSA 1978 [repealed] except as are reasonably necessary or desirable to promote the health and safety of persons using group homes.

History: 1953 Comp., § 12-34-5, enacted by Laws 1973, ch. 359, § 5; 1975, ch. 183, § 3; 1979, ch. 33, § 1; 1983, ch. 185, § 1; 1987, ch. 31, § 2; 1989, ch. 138, § 1; 1990, ch. 105, § 1; 1996, ch. 35, § 2; 1997, ch. 113, § 1; 1998, ch. 55, § 32; 1999, ch. 265, § 34; 2003, ch. 120, § 1; 2005, ch. 53, § 1; 2015, ch. 153, § 2; 2017, ch. 87, § 7.

24-1-5.1. Repealed.

24-1-5.2. Health facilities; intermediate sanctions; civil penalty.

A. Upon a determination that a health facility is not in compliance with any licensing requirement of the department, the department, subject to the provisions of this section and Section 24-1-5 NMSA 1978, may:

(1) impose any intermediate sanction established by rule, including but not limited to:

(a) a directed plan of correction;

(b) facility monitors;

(c) denial of payment for new medicaid admissions to the facility;

(d) temporary management or receivership; and

(e) restricted admissions;

(2) assess a civil monetary penalty, with interest, for each day the facility is or was out of compliance. Civil monetary penalties shall not exceed a total of five thousand dollars ($5,000) per day. Penalties and interest amounts assessed under this paragraph and recovered on behalf of the state shall be remitted to the department in a recurring account in the state treasury for the sole purpose of funding the nonreimbursed cost of

facility monitors, temporary management and health facility receiverships. The civil monetary penalties contained in this paragraph are cumulative and may be imposed in addition to any other fines or penalties provided by law; and

(3) with respect to health facilities other than childcare centers or facilities, proceed pursuant to the Health Facility Receivership Act [Chapter 24A, Article 2 NMSA 1978].

B. The secretary shall adopt and promulgate rules specifying the criteria for imposition of any intermediate sanction and civil monetary penalty. The criteria shall provide for more severe sanctions for a violation that results in any abuse, neglect or exploitation of residents, clients or patients as defined in the rules or that places one or more residents, clients or patients of a health facility at substantial risk of serious physical or mental harm.

C. The provisions of this section for intermediate sanctions and civil monetary penalties shall apply to certified nursing facilities except when a federal agency has imposed the same remedies, sanctions or penalties for the same or similar violations.

D. Rules adopted by the department shall permit sanctions pursuant to Paragraphs (1) and (2) of Subsection A of this section for a specific violation in a certified nursing facility if:

(1) the state statute or rule is not duplicated by a federal certification rule; or

(2) the department determines intermediate sanctions are necessary if sanctions permitted pursuant to Paragraphs (1) and (2) of Subsection A of this section do not duplicate a sanction imposed under the authority of 42 U.S.C. 1395 or 1396 for a particular deficiency.

E. A health facility is liable for the reasonable costs of a directed plan of correction, facility monitors, temporary management or receivership imposed pursuant to this section and Section 24-1-5 NMSA 1978. The department may take all necessary and appropriate legal action to recover these costs from a health facility. All money recovered from a health facility pursuant to this subsection shall be paid into the general fund.

History: 1978 Comp., § 24-1-5.2, enacted by Laws 1990, ch. 105, § 2; 1996, ch. 35, § 3; 2005, ch. 53, § 2.

24-1-5.3. Repealed.

24-1-5.4. Repealed.

History: Laws 1997, ch. 217, § 2; repealed by Laws 2023, ch. 113, § 13.

24-1-5.5. Repealed.

24-1-5.6. Northern New Mexico substance abuse treatment pilot project.

A. The department of health shall establish the northern New Mexico substance abuse treatment pilot project.

B. The northern New Mexico substance abuse treatment pilot project shall provide substance abuse treatment in Rio Arriba and Santa Fe counties.

C. Currently accepted treatment practices shall be used in the northern New Mexico substance abuse treatment pilot program [project].

D. The department of health shall seek federal funding to support and supplement the northern New Mexico substance abuse treatment pilot project.

E. The department of health shall report to the legislature annually by December 1 on the progress of the northern New Mexico substance abuse treatment pilot project.

F. The department of health shall coordinate with the human services department [health care authority department] to determine whether any patient who participates in the northern New Mexico substance abuse treatment pilot project is eligible to receive temporary assistance for needy families pursuant to the New Mexico Works Act [Chapter 27, Article 2B NMSA 1978].

History: Laws 1999 (1st S.S.), ch. 8, § 1.

24-1-5.7. Recompiled.

History: Laws 2003, ch. 190, § 1; 2007, ch. 325, § 7; § 24-1-5.7, recompiled and amended as § 24A-1-12 by Laws 2024, ch. 39, § 33.

24-1-5.8. Recompiled.

History: Laws 2003, ch. 426, § 1; § 24-1-5.8, recompiled and amended as § 24A-1-7 by Laws 2024, ch. 39, § 28.

24-1-5.9. Recompiled.

History: Laws 2004, ch. 44, § 2; 2004, ch. 50, § 2; § 24-1-5.9, recompiled and amended as § 24A-1-8 by Laws 2024, ch. 39, § 29.

24-1-5.10. Recompiled.

History: Laws 2004, ch. 47, § 1; § 24-1-5.10 recompiled and amended as § 24A-1-9 by Laws 2024, ch. 39, § 30.

24-1-5.11. Medication-assisted treatment for the incarcerated program fund; created.

A. The "medication-assisted treatment for the incarcerated program fund" is created as a nonreverting fund in the state treasury. The fund consists of appropriations, gifts, grants and donations. The human services department [health care authority department] shall administer the fund, and money in the fund is appropriated to the human services department [health care authority department] to assist all counties that operate correctional facilities to establish and operate medication-assisted treatment programs for people who are incarcerated in county correctional facilities. Disbursements from the fund shall be made by warrants of the secretary of finance and administration pursuant to vouchers signed by the secretary of human services.

B. No later than December 1, 2023, the human services department [health care authority department] shall promulgate rules for the operation of medication-assisted treatment programs in correctional facilities in consultation with the corrections department, county corrections administrators and providers who specialize in substance use disorder treatment and have experience working in corrections settings.

C. Beginning October 1, 2023 and annually thereafter, the human services department [health care authority department] and the corrections department shall report to the interim legislative health and human services committee and the legislative finance committee on the establishment and operation of medication-assisted treatment programs in correctional facilities.

D. The corrections department shall:

(1) expand and continue to operate currently existing medication-assisted treatment programs for people who are incarcerated in a state correctional facility;

(2) by December 31, 2025, establish and operate a medication-assisted treatment program to continue medication-assisted treatment for incarcerated people with a prescription who are booked into a state correctional facility; and

(3) by the end of fiscal year 2026, offer medication-assisted treatment to all people who are incarcerated in state correctional facilities and in need of medication-assisted treatment.

E. As used in this section:

(1) "correctional facility" means a prison or other detention facility, whether operated by a government or private contractor, that is used for confinement of adult persons who are charged with or convicted of a violation of a law or an ordinance; and

(2) "medication-assisted treatment" means the use of federal food and drug administration-approved prescription drugs for the treatment of substance use disorder.

History: Laws 2023, ch. 49, § 1.

24-1-5.12. Recompiled.

History: Laws 2023, ch. 109, § 1; § 24-1-5.12, recompiled and amended as § 24A-1-10 by Laws 2024, ch. 39, § 31.

24-1-6. Tests required for newborn infants.

A. The department shall adopt screening tests for the detection of congenital diseases that shall be given to every newborn infant, except that, after being informed of the reasons for the tests, the parents or guardians of the newborn child may waive the requirements for the tests in writing. The screening tests shall include at a minimum:

(1) 3-methylcrotonyl-CoA deficiency;

(2) 3-OH 3-CH3 glutaric aciduria;

(3) argininosuccinic acidemia;

(4) mitochondrial acetoacetyl-CoA thiolase deficiency;

(5) biotinidase deficiency;

(6) carnitine uptake defect;

(7) citrullinemia;

(8) congenital adrenal hyperplasia;

(9) congenital hypothyroidism;

(10) cystic fibrosis;

(11) galactosemia;

(12) glutaric acidemia type I;

(13) Hb S/beta-thalassemia;

(14) hearing deficiency;

(15) homocystinuria;

(16) isovaleric acidemia;

(17) long-chain L-3-OH acyl-CoA dehydrogenase deficiency;

(18) maple syrup urine disease;

(19) medium chain acyl-CoA dehydrogenase deficiency;

(20) methylmalonic acidemia;

(21) multiple carboxylase deficiency;

(22) phenylketonuria;

(23) proponic acidemia;

(24) sickle cell anemia;

(25) trifunctional protein deficiency;

(26) tyrosinemia type I;

(27) very long-chain acyl-CoA dehydrogenase deficiency; and

(28) critical congenital heart disease by means of a test performed using a pulse oximeter before the newborn infant is discharged from the hospital or birthing facility where the newborn infant was born. For the purposes of this paragraph, "pulse oximeter" means a device that measures the oxygen saturation of arterial blood.

B. Upon the later of either January 1, 2011 or when the secretary finds that these screening tests are reasonably available, the department shall adopt screening tests for the detection of the following genetic diseases that shall be given to every newborn infant; except that, after being informed of the reasons for the tests, the parents or guardians of the newborn child may waive the requirements of the tests in writing. The screening tests shall include:

(1) acid maltase deficiency or glycogen storage disease type II;

(2) globoid cell leukodystrophy;

(3) Gaucher's disease;

(4) Niemann-Pick disease; and

(5) Fabry disease.

C. In determining which other congenital diseases to screen for, the secretary shall consider the recommendations of the New Mexico pediatric society of the American academy of pediatrics.

D. The department shall institute and carry on such laboratory services or may contract with another agency or entity to provide such services as are necessary to detect the presence of congenital diseases.

E. The department shall, as necessary, carry on an educational program among physicians, hospitals, public health nurses and the public concerning congenital diseases.

F. The department shall require that all hospitals or institutions having facilities for childbirth perform or have performed screening tests for congenital diseases on all newborn infants except if the parents or guardians of a child object to the tests in writing.

History: 1953 Comp., § 12-34-6, enacted by Laws 1973, ch. 359, § 6; 1975, ch. 254, § 1; 1978, ch. 83, § 1; 1981, ch. 95, § 1; 2005, ch. 134, § 1; 2010, ch. 91, § 1; 2014, ch. 7, § 1.

24-1-6.1. Newborn hearing testing required; department of health.

By July 1, 2001, the department of health shall adopt rules to require that infants born in health facilities licensed by the department shall be screened for hearing sensitivity prior to being discharged. The rules shall also require the testing of newborns brought to licensed health facilities after birth who have not received a hearing sensitivity screening and notification to the parents of all screened infants of the results of the hearing sensitivity screening. Nothing in this section shall be construed to require screening for hearing sensitivity of a newborn infant if the infant's parents object to the screening on the grounds that it conflicts with their religious beliefs.

History: Laws 2001, ch. 82, § 1.

24-1-7. Sexually transmitted infections; reports of cases.

A. The department shall make available a list of sexually transmitted infections for which reporting is required.

B. Reports of sexually transmitted infections shall be made in accordance with department rules.

C. Every health care provider that makes a diagnosis of, treats or prescribes for or otherwise has knowledge of a case of sexually transmitted infection for which reporting is required by department rules shall report the case immediately.

D. As used in this section, "health care provider" means:

(1) a person licensed to provide health care in the ordinary course of business;

(2) a superintendent or manager of a health care clinic;

(3) a dispensary, a charitable or penal institution or a municipal or county detention center; or

(4) a laboratory that performs testing for sexually transmitted infections.

History: 1953 Comp., § 12-34-7, enacted by Laws 1973, ch. 359, § 7; 1993, ch. 341, § 1; 1978 Comp., § 24-1-7, repealed and reenacted by Laws 2017, ch. 87, § 8.

24-1-8. Repealed.

History: 1953 Comp., § 12-34-8, enacted by Laws 1973, ch. 359, § 8; 1993, ch. 341, § 2; repealed by Laws 2017, ch. 87, § 31.

24-1-9. Capacity to consent to examination, preventive care and treatment for a sexually transmitted infection.

Any person regardless of age has the capacity to consent to an examination, preventive care and treatment by a licensed health care provider for any sexually transmitted infection.

History: 1953 Comp., § 12-34-9, enacted by Laws 1973, ch. 359, § 9; 1993, ch. 341, § 3; 2017, ch. 87, § 9; 2023, ch. 99, § 6.

24-1-9.1. Sexually transmitted infections; testing of persons convicted of certain criminal offenses.

A. A test designed to identify any sexually transmitted infection may be performed on an offender convicted pursuant to state law of any criminal offense:

(1) involving contact between the penis and the vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva;

(5) involving contact between the mouth and anus; or

(6) when the court determines from the facts of the case that there was a transmission or likelihood of transmission of bodily fluids from the offender to the victim of the criminal offense.

B. When consent to perform a test on an offender cannot be obtained, the victim of a criminal offense described in Subsection A of this section may petition the court to order that a test be performed on the offender. When the victim of the criminal offense is a minor or incompetent, the parent or legal guardian of the victim may petition the court to order that a test be performed on the offender. The court shall order and the test shall be administered to the offender within ten days after the petition is filed by the victim or the victim's parent or guardian. Except for disclosures made pursuant to Section 24-1-7 NMSA 1978, the results of the test shall be disclosed only to the offender and to the victim or the victim's parent or legal guardian.

History: 1978 Comp., § 24-1-9.1, enacted by Laws 1993, ch. 341, § 4; 2017, ch. 87, § 10.

24-1-9.2. Sexually transmitted infections; testing of persons formally charged for allegedly committing certain criminal offenses.

A. A test designed to identify any sexually transmitted infection may be performed on a person, upon the filing of a complaint, information or an indictment alleging that the person committed a state criminal offense:

(1) involving contact between the penis and the vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva; or

(5) involving contact between the mouth and anus.

B. If consent to perform a test on an alleged offender cannot be obtained, the victim of the alleged criminal offense described in Subsection A of this section may petition the court, through the prosecuting office or personally, to order that a test be performed on the alleged offender; provided that the same test is first performed on the victim of the alleged criminal offense. The test may be performed on the alleged offender regardless of the result of the test performed on the victim of the alleged criminal offense. If the victim of the alleged criminal offense is a minor or incompetent, the parent or legal guardian of the victim of the alleged criminal offense may petition the court to order that a test be performed on the alleged offender.

C. The court may issue an order based on a finding of good cause after a hearing at which both the victim of the alleged criminal offense and the alleged offender have the

right to be present. During the hearing, only affidavits, counter affidavits and medical reports regarding the facts that support or rebut the issuance of an order shall be admissible. The hearing shall be conducted within seventy-two hours after the victim petitions the court for the order. The petition and all proceedings in connection therewith shall be under seal. The court shall issue an order and the test shall be administered to the alleged offender within ten days after the petition is filed by the victim of the alleged criminal offense or the victim's parent or legal guardian.

D. Except for disclosures made pursuant to Section 24-1-7 NMSA 1978, the results of the test shall be disclosed only to the alleged offender and to the victim of the alleged criminal offense or the victim's parent or legal guardian. When the victim of the alleged criminal offense or the alleged offender has a positive test result, both the alleged offender and the victim of the alleged criminal offense shall be provided with counseling.

E. A prosecuting attorney may not use in a criminal proceeding arising out of the alleged criminal offense the fact that a test was administered to the alleged offender or the results of the test.

F. The provisions of this section shall not affect the rights and remedies available to the victim of the alleged criminal offense and the alleged offender in any civil action.

G. The administration of a test to an alleged offender pursuant to the provisions of this section shall not preclude the subsequent administration of another test pursuant to the provisions of Section 24-1-9.1 NMSA 1978.

History: 1978 Comp., § 24-1-9.2, enacted by Laws 1996, ch. 80, § 1; 2017, ch. 87, § 11.

24-1-9.3. Sexually transmitted infections; mandatory counseling.

No positive test result for a sexually transmitted infection shall be revealed to the person upon whom the test was performed without the person performing the test or the health facility at which the test was performed providing or referring that person for individual counseling about:

A. the meaning of the test results;

B. the possible need for additional testing;

C. the availability of appropriate health care services, including mental health care, social services and support services; and

D. the benefits of locating and counseling any individual by whom the infected person may have been exposed to the sexually transmitted infection and any individual whom the infected person may have exposed to the sexually transmitted infection.

History: 1978 Comp., § 24-1-9.3, enacted by Laws 1996, ch. 80, § 2; 2017, ch. 87, § 12.

24-1-9.4. Sexually transmitted infections; confidentiality.

A. Except as provided in Section 24-1-9.2 NMSA 1978, no person or the person's agents or employees who require or administer a test for sexually transmitted infections shall disclose the identity of any person upon whom a test is performed or the result of such a test in a manner that permits identification of the subject of the test, except to the following persons:

(1) the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

(2) any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

(3) an authorized agent, a credentialed or privileged physician or an employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

(4) the department of health and the centers for disease control and prevention of the United States public health service in accordance with reporting requirements for a diagnosed case of a sexually transmitted infection;

(5) a health facility or health care provider that procures, processes, distributes or uses:

(a) a human body part from a deceased person, with respect to medical information regarding that person;

(b) semen for the purpose of artificial insemination;

(c) blood or blood products for transfusion or injection; or

(d) human body parts for transplant with respect to medical information regarding the donor or recipient;

(6) health facility staff committees or accreditation or oversight review organizations that are conducting program monitoring, program evaluation or service reviews, as long as any identity remains confidential;

(7) authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

(8) for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

B. Whenever disclosure is made, it shall be accompanied by a statement in writing that includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom this information pertains or as otherwise permitted by law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both.".

History: 1978 Comp., § 24-1-9.4, enacted by Laws 1996, ch. 80, § 3; 2017, ch. 87, § 13.

24-1-9.5. Repealed.

History: 1978 Comp., § 24-1-9.5, enacted by Laws 1996, ch. 80, § 4; repealed by Laws 2017, ch. 87, § 31.

24-1-9.6. Sexually transmitted infections; disclosure.

A. A victim of a criminal offense or an alleged criminal offense who receives information pursuant to Section 24-1-9.1 or 24-1-9.2 NMSA 1978 may disclose the offender's or alleged offender's test results to the victim's health care provider as is reasonably necessary to protect the victim's health and safety or the health and safety of the victim's family or sexual partner.

B. Nothing in this section shall be construed to prevent a person who has been tested from disclosing in any way to any other person that person's own test results.

History: 1978 Comp., § 24-1-9.6, enacted by Laws 1996, ch. 80, § 5; 2017, ch. 87, § 14.

24-1-9.7. Penalty.

A person who, in violation of Section 24-1-9.4 NMSA 1978, makes an unauthorized disclosure of the results of a test designed to identify a sexually transmitted infection is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500) or both.

History: 1978 Comp., § 24-1-9.7, enacted by Laws 1996, ch. 80, § 6; 2017, ch. 87, § 15.

24-1-10. Pregnancy; serological test for syphilis.

A. Every physician examining a pregnant woman for conditions relating to her pregnancy during the period of gestation or at delivery or both shall take or cause to be taken a sample of blood of such woman at the time of first examination.

B. All such blood samples shall be submitted to the state public health laboratory for a standard serological test for syphilis.

C. The standard serological test shall be a test for syphilis approved by the director of the department. Such serological tests shall be made on request without charge by the department.

History: 1953 Comp., § 12-34-10, enacted by Laws 1973, ch. 359, § 10.

24-1-11. Reporting of blood tests.

In reporting every birth and stillbirth, physicians and others required to make such reports shall state on the certificate whether a blood test for syphilis has been made upon a specimen of blood taken from the mother of the child for which a birth or stillbirth certificate is filed and the approximate date when the specimen was taken.

History: 1953 Comp., § 12-34-11, enacted by Laws 1973, ch. 359, § 11.

24-1-12. Health certificates; filing.

A. Any person who operates or is employed in a health facility shall, upon becoming employed or engaged in such occupation, present to the employer or, if self-employed, file at the place of business a health certificate from a licensed physician stating the person is free from communicable diseases in a transmissible state dangerous to the public health as defined by regulation of the health services division [public health division] of the health and environment department [department of health]. The certificate shall be obtained not more than ninety days prior to the date of employment.

B. All certificates shall be kept on file and be subject to inspection by the licensing authority.

History: 1953 Comp., § 12-34-12, enacted by Laws 1973, ch. 359, § 12; 1981, ch. 46, § 1.

24-1-13. Pregnancy; capacity to consent to examination and diagnosis.

Any person, regardless of age, has the capacity to consent to an examination and diagnosis by a licensed physician for pregnancy.

History: 1953 Comp., § 12-34-13, enacted by Laws 1973, ch. 359, § 13.

24-1-13.1. Pregnancy; prenatal, delivery and postnatal treatment to a female minor; capacity to consent.

A health care provider shall have the authority, within the limits of his license, to provide prenatal, delivery and postnatal care to a female minor. A female minor shall have the capacity to consent to prenatal, delivery and postnatal care by a licensed health care provider.

History: Laws 2001, ch. 314, § 1 and Laws 2001, ch. 327, § 1.

24-1-13.2. Shaken baby syndrome prevention.

The department of health shall adopt rules, no later than December 31, 2017, requiring every hospital and freestanding birthing center to provide training and education to prevent shaken baby syndrome to every parent of every newborn before discharge of the newborn from the health facility. The rules shall require the health facility to maintain records to demonstrate compliance with this requirement and to report such information as the department deems appropriate regarding the training and education provided by such health facility. The department, in collaboration with the university of New Mexico health sciences center's department of pediatrics, shall approve training and instructional materials in both English and Spanish and shall include the use of shaken baby simulation dolls in the required curriculum.

History: Laws 2017, ch. 119, § 1.

24-1-14. [Sterilization;] special qualifications prohibited.

No hospital which permits any operation that results in sterilization to be performed therein or medical staff of such hospital shall require any person upon whom a sterilization operation is to be performed to meet any special qualifications which are not imposed on individuals seeking other types of operations in the hospital.

History: 1953 Comp., § 12-34-14, enacted by Laws 1973, ch. 359, § 14.

24-1-15. Isolation; quarantine; protocol.

A. If the secretary or a representative of the department has knowledge that a person is infected with or reasonably believes that a person is infected with or exposed to a threatening communicable disease and the person has refused voluntary treatment, testing, evaluation, detention or observation, the secretary or the secretary's designee

shall petition the court for an order to isolate or quarantine the person until the person is no longer a threat to the public health or until the person voluntarily complies with treatment and contagion precautions.

B. The secretary or a representative of the department whom the secretary designates may, by public health order, temporarily isolate or quarantine a person or group of persons if delay in isolating or quarantining would significantly jeopardize the secretary's ability to prevent or limit the transmission to others of a threatening communicable disease. The public health order shall expire at the end of twenty-four hours from the time of the commencement of the isolation or quarantine. The secretary may petition for a court order that authorizes the continued isolation or quarantine of the person or group of persons. In the petition, the secretary shall present facts used to support the need to have issued the public health order to isolate or quarantine.

C. Whether or not a public health order to isolate or quarantine was previously issued, a petition for a court order shall be made under oath or shall be accompanied by a sworn affidavit setting out specific facts showing the basis upon which isolation or quarantine is justified, including whether a person to be isolated or quarantined:

(1) is infected with, reasonably believed to be infected with or exposed to a threatening communicable disease; and

(2) poses a substantial likelihood of transmission of the threatening communicable disease to others because of inadequate separation from others.

D. Upon the filing of a petition, the court shall:

(1) immediately grant ex parte a court order to isolate or quarantine the affected person if there is probable cause from the specific facts shown by the affidavit or by the petition to give the judge reason to believe that the affected person poses a substantial threat to the public health and safety;

(2) cause the court order, notice of hearing and an advisement of the terms of the court order, including the affected person's rights to representation and re-petition for termination of a court order that removes and detains the affected person, to be immediately served on the affected person; and

(3) within five days after the granting of the court order, hold an evidentiary hearing to determine if the court shall continue the order.

E. A person held pursuant to a court order as set forth in Subsection D of this section shall be:

(1) entitled to representation by counsel at the evidentiary hearing and at all hearings thereafter for the duration of the period of removal and detention; and

(2) permitted to communicate on any matter, including the person's isolation or quarantine, with persons by telephone, or other reasonably available means that do not expose other persons to the risk of infection, for the duration of the period of isolation or quarantine.

F. Counsel may be retained by the person held or shall be appointed by the court if the court determines that the person held cannot afford legal representation or if the court determines that appointment of counsel is required in the interest of justice.

G. At the evidentiary hearing, the court shall review the circumstances surrounding the court order and, if the petitioner can show by clear and convincing evidence that the person being held has not voluntarily complied or will not voluntarily comply with appropriate treatment and contagion precautions, the court may continue the isolation or quarantine. The court shall order regular review of the order to isolate or quarantine by providing the person being held with a subsequent hearing within thirty days of the court order's issuance and every thirty days thereafter. The court order to isolate or quarantine shall be terminated and the affected person shall be released if:

(1) the person being held is certified by a public health official to pose no further risk to the public health;

(2) at a hearing, the petitioner, whose burden of proof continues under a clear and convincing standard, can no longer show that the person being held is infected with, reasonably believed to be infected with or exposed to a threatening communicable disease and that the affected person will not comply with appropriate treatment and contagion precautions voluntarily; or

(3) exceptional circumstances exist warranting the termination of the court order.

H. The provisions of this section do not permit the forcible administration of medications. A person isolated or quarantined pursuant to this section has the right to refuse to participate in medical treatment, testing, physical or mental examination, vaccination, specimen collection or preventive treatment.

I. A person who is isolated or quarantined pursuant to a court order may petition the court to contest the order or the conditions of isolation or quarantine at any time prior to the expiration of the order. If a petition is filed, the court shall hold a hearing within five days after the date of filing. The filing of a petition for a hearing pursuant to this subsection does not stay a court order for isolation or quarantine. At the hearing, the secretary shall offer clear and convincing evidence that:

(1) the isolation or quarantine is warranted; or

(2) the conditions of isolation or quarantine are compliant with the provisions of this section.

J. When isolating or quarantining an affected person, the secretary shall ensure that:

(1) isolation or quarantine is the least restrictive means necessary to protect against the spread to others of a communicable disease or a potentially threatening communicable disease and may include confinement to the affected person's private home, if practicable, or if not practicable, to a private or public premises;

(2) an isolated person is confined separately from a quarantined person;

(3) the health status of an isolated or quarantined person is monitored regularly to determine whether continued isolation or quarantine is required;

(4) if a quarantined person becomes infected or is reasonably believed to be infected with the threatening communicable disease subsequent to quarantine, that affected person shall be promptly isolated;

(5) the needs of a person isolated or quarantined are addressed in a systematic and orderly manner, including the provision of adequate food, clothing, shelter, sanitation and comfort;

(6) there are methods of communication available to a person placed in isolation or quarantine to enable communication with family members, household members, legal representatives, advocates, the media and any licensed health care provider;

(7) an area of isolation or quarantine is maintained in a manner that minimizes the likelihood of further transmission of infection or other injury to other persons who are isolated or quarantined; and

(8) to the extent possible, cultural and religious beliefs shall be respected in addressing the needs of affected persons and in establishing and maintaining an area of isolation or quarantine.

K. A person shall not enter an area of isolation or quarantine except as authorized by the department. To protect the public health, the department may isolate or quarantine any person who has entered, with or without the secretary's authorization, into an area of isolation or quarantine.

L. Court proceedings shall be on the record and be closed to the general public. The records shall be sealed from public inspection.

M. A person who in good faith reports another person infected with a threatening communicable disease shall not be held liable for civil damages as a result of the report; provided that the person reported as being infected with a threatening communicable disease shall have the right to sue for damages sustained as a result of negligent or

intentional reporting of inaccurate information or the disclosure of information to an unauthorized person.

N. During the period of isolation or quarantine, an employer shall not discharge from employment a person who is placed in isolation or quarantine pursuant to this section.

O. The secretary, after consultation with the state medical investigator, the secretary of public safety, the director and the chair of the board of funeral services, may implement and enforce measures that are reasonable and necessary to respond to a threatening communicable disease and provide for the safe disposal of human remains.

P. For purposes of this section:

(1) "area of isolation or quarantine" means the physical environs that the department designates as the area within which to restrict access as required to prevent transmission of a threatening communicable disease;

(2) "court" means:

(a) the district court of the judicial district where the person who is alleged to be infected with a threatening communicable disease resides or is found; or

(b) in the event that a district court cannot adequately provide services, a district court that the New Mexico supreme court designates;

(3) "isolate" means to physically separate for possible medical care a person who is infected or who is reasonably believed to be infected with a threatening communicable disease or potentially threatening communicable disease;

(4) "public health official" means the secretary, a regional health officer, the director of the public health division of the department, a chief medical officer or a representative of the department designated by the secretary to carry out the duties provided in this section;

(5) "quarantine" means the precautionary physical separation of a person who has or may have been exposed to a threatening communicable disease or a potentially threatening communicable disease and who does not show a sign or symptom of a threatening communicable disease from persons who are not quarantined to protect against the transmission of the disease to persons who are not quarantined; and

(6) "threatening communicable disease" means a disease that causes death or great bodily harm, passes from one person to another and for which there is no means by which the public reasonably can avoid the risk of contracting the disease.

History: 1953 Comp., § 12-34-15, enacted by Laws 1973, ch. 359, § 15; 1999, ch. 159, § 1; 2002, ch. 74, § 1; 2017, ch. 87, § 16.

24-1-15.1. Protocol for management of active tuberculosis.

A. When a physician or other person knows that a person has, or is reasonably believed to be infected with, active tuberculosis, the physician or other person shall promptly notify the department.

B. Upon receiving notification that a person has active tuberculosis, the department shall prescribe the person a treatment plan meeting the department's therapeutic specifications for the infectious form of tuberculosis. The treatment plan shall include a notice to the person that failure to comply with the treatment plan will result in immediate initiation of court action to ensure compliance, as set forth in this section.

C. The secretary, or a representative of the department whom the secretary designates, may by public health order temporarily isolate a person or group of persons if delay in isolating the person or group would significantly jeopardize the secretary's ability to prevent or limit the transmission of tuberculosis to others. The public health order shall expire at the end of twenty-four hours from the time of the commencement of isolation. The secretary may petition for a court order that authorizes the continued isolation. In the petition, the secretary shall present facts used to support the need to have issued the public health order to isolate.

D. Whether or not a public health order was issued pursuant to Subsection C of this section, when the department has knowledge that a person who has active tuberculosis has failed to comply with the department's treatment plan as described in Subsection B of this section, the department shall petition for a court order for the person who has active tuberculosis to comply with whichever of the following courses of action the department deems appropriate:

(1) a program of directly observed therapy;

(2) isolation; or

(3) directly observed therapy and isolation.

E. A petition for a court order shall be made under oath or shall be accompanied by a sworn affidavit setting out specific facts showing the basis upon which isolation is justified, including whether the person to be isolated:

(1) has active tuberculosis or presents a substantial likelihood of having active tuberculosis based on credible medical evidence;

(2) after being advised of the condition and the risks posed thereby, has failed to comply with the department's treatment plan; and

(3) poses a substantial likelihood of transmission of tuberculosis to others because the person is actively infectious or poses a risk of relapse or development of a therapy-resistant strain of tuberculosis.

F. Upon the filing of a petition for a court order, the court shall:

(1) in cases where there is probable cause established by the petition to give the judge reason to believe that the person who has been alleged to have active tuberculosis poses a substantial threat to the public health and safety because the person is actively infectious, or poses a risk of relapse or development of a therapy-resistant strain of tuberculosis because of a history of noncompliance, immediately grant ex parte a court order to:

(a) administer a program of directly observed therapy;

(b) isolate the person and administer a program of directly observed therapy; or

(c) isolate the person, if the person refuses a program of directly observed therapy;

(2) cause the court order, notice of hearing and an advisement of the terms of the court order, including the rights of the person alleged to have active tuberculosis to representation and re-petition for termination of a court order, to be immediately served on the person alleged to have active tuberculosis; and

(3) within five days after the granting of the court order, hold an evidentiary hearing to determine if the court shall continue the court order.

G. A person held pursuant to a court order as set forth in Subsection F of this section shall be:

(1) entitled to representation by counsel at the evidentiary hearing and at all hearings thereafter for the duration of the period of isolation or program of directly observed therapy; and

(2) permitted to communicate on any matter, including the person's isolation or program of directly observed therapy, with persons by telephone or other reasonably available means that do not expose other persons to the risk of infection, for the duration of the period of isolation or program of directly observed therapy.

H. Counsel may be retained by the person under the court order or shall be appointed by the court if the court determines that the person held cannot afford legal representation or if the court determines that appointment of counsel is required in the interest of justice.

I. At the evidentiary hearing, the court shall review the circumstances surrounding the court order, and, if the petitioner can show by clear and convincing evidence that the person being held has not complied or will not comply with appropriate treatment and contagion precautions as the department deems necessary, the court shall continue the court order for the person who has active tuberculosis until completion of therapy, as deemed by the department. The court shall order regular review of the order by providing the person under a court order with a subsequent hearing within ninety days of the court order's issuance and every ninety days thereafter. The court order shall be terminated and the person shall be released if:

(1) at a hearing, the petitioner has not met its burden of showing by clear and convincing proof that the person under a court order has not completed therapy; or

(2) exceptional circumstances exist warranting the termination of the court order.

J. The provisions of this section do not permit the forcible administration of medications.

K. A person isolated pursuant to this section has the right to refuse any medical treatment, physical or mental examination, treatment program or invasive specimen collection. A person who has been directed by the secretary to submit to medical procedures and protocols because the person has active tuberculosis and refuses to submit to the procedures and protocols may be subject to continued isolation pursuant to this section.

L. A person who is isolated pursuant to a court order may petition the court to contest the order or the conditions of isolation at any time prior to the expiration of the court order. If a petition is filed, the court shall hold a hearing within five business days after the date of filing. At a hearing pursuant to a petition to contest, the secretary shall offer:

(1) clear and convincing evidence that the isolation is warranted; or

(2) proof that the conditions of isolation are compliant with the provisions of this section.

M. When isolating a person or group of persons, the secretary shall ensure that:

(1) isolation is imposed by the least restrictive means necessary to protect against the spread of tuberculosis to others and may include confinement to the isolated person's private home, if practicable, or, if not practicable, a private or public premises;

(2) the health status of an isolated person is monitored regularly to determine if continued isolation is required;

(3) the needs of a person isolated are addressed in a systematic and orderly manner, including the provision of adequate food, clothing, shelter, sanitation and comfort;

(4) there are methods of communication available to a person placed in isolation to enable communication with family members, household members, legal representatives, advocates, the media and any licensed health care provider;

(5) the premises used for isolation are maintained in a manner that minimizes the likelihood of further transmission of infection or other injury to other persons who are isolated; and

(6) to the extent possible, cultural and religious beliefs shall be respected in addressing the needs of persons and establishing and maintaining isolation premises.

N. The proceedings of any hearing held pursuant to this section shall be recorded stenographically, electronically or mechanically or by other appropriate means. The proceedings shall be closed to the general public and the records shall be sealed from public inspection.

O. A person who in good faith reports that another person has active tuberculosis shall not be held liable for civil damages as a result of the report; provided that the person reported as having active tuberculosis shall have the right to sue for damages sustained as a result of negligent or intentional reporting of inaccurate information or the disclosure of information to an unauthorized person.

P. During the period of isolation, an employer shall not discharge from employment a person who is placed in isolation pursuant to this section.

Q. For purposes of this section:

(1) "active tuberculosis" means a disease caused by mycobacterium tuberculosis or other members of the mycobacterium tuberculosis complex family that has been determined, through current clinical, bacteriological or radiographic evidence, or whichever diagnostic procedures the department deems appropriate, to be present in a person who has not completed an appropriate course of antituberculosis medication, regardless of the state of communicability of the disease. A person with active tuberculosis includes a person with:

(a) tuberculosis that is resistant to the prescribed treatment plan;

(b) infectious tuberculosis or who presents a substantial likelihood of having infectious tuberculosis based on credible medical evidence;

(c) noninfectious tuberculosis who is at high risk of developing an infectious form of tuberculosis; and

(d) pulmonary or extrapulmonary tuberculosis;

(2) "completion of therapy" means completion of the prescribed therapy, as determined by the department based upon published national consensus tuberculosis treatment guidelines;

(3) "court" means the district court of the judicial district where the person who is alleged to have active tuberculosis resides or is found or a district court designated by the New Mexico supreme court;

(4) "department" means the department of health or a person designated by the secretary of health to carry out the duties provided in this section;

(5) "directly observed therapy" means a methodology for promoting patient adherence in which a health care provider or trained designee witnesses the patient ingest each dose of medication until the completion of prescribed therapy for tuberculosis; and

(6) "isolation" means:

(a) home isolation;

(b) home isolation with electronic monitoring;

(c) isolation in a hospital or other health care facility negative pressure room where appropriate security measures are undertaken to prevent the transmission of tuberculosis; or

(d) isolation in a prison or detention center negative pressure room with an appropriate level of medical care.

History: Laws 2009, ch. 174, § 1; 2017, ch. 87, § 17.

24-1-15.2. Conditions of public health importance; reporting.

A. The secretary shall establish by rule a list of reportable conditions of public health importance. The list shall include conditions of humans or animals caused by exposure to toxic substances, microorganisms or any other pathogens or conditions that arise due to injury. The secretary shall:

(1) prescribe the manner of and the person responsible for reporting conditions of public health importance;

(2) classify each reportable condition of public health importance according to the urgency of reporting; and

(3) revise the list of reportable conditions of public health importance as necessary.

B. The secretary may enter into agreements or other arrangements with federal and tribal public health agencies for receipt and sharing of information regarding reportable conditions of public health importance.

C. The department shall disseminate reporting requirements to health care providers and other persons required to report conditions of public health importance.

D. A person with knowledge of a reportable condition of public health importance shall report the condition to the department.

History: Laws 2017, ch. 87, § 18.

24-1-15.3. Conditions of public health importance; testing; screening.

A. The department shall establish testing and screening procedures and programs to identify conditions of public health importance among individuals or among the general population of the state. The department shall:

(1) prior to testing or screening, explain to the individual the nature, scope, purposes, benefits, risks and possible outcomes of the test or screening, except as otherwise provided pursuant to this section or by state law;

(2) have a valid and reliable test for the condition of public health importance;

(3) when administering a test or screening, identify a condition of public health importance that poses a threat to an individual's or the public's health and that may be avoided, cured, alleviated or made less contagious through safe and effective treatment, modifications in individual behavior or public health interventions; and

(4) fully inform the individual of the individual's results, the meaning of the results, the possible need for additional testing and the availability of appropriate health care services, including mental health care and social and support services. If appropriate, the department shall provide counseling or inform the individual where such counseling services are available.

B. The department may petition for the issuance of a court order to require testing or medical examination of any individual who has or may have been exposed to a condition of public health importance that poses a significant risk or threat to the individual or others or to the public's health, in accordance with procedures established by department rules.

History: Laws 2017, ch. 87, § 19.

24-1-15.4. Individually identifiable health information; conditions of public health importance; confidentiality; use; disclosure.

A. Any use of individually identifiable health information pursuant to this section shall be limited to the minimum amount of information reasonably necessary to accomplish a public health purpose.

B. Individually identifiable health information received by the department shall not be public information and shall not be disclosed without the authorization of the individual who is the subject of the information, except as otherwise provided in state or federal law.

C. In accordance with state and federal law, the secretary shall adopt and promulgate rules to allow an individual to have access to, inspect and obtain copies of the individual's individually identifiable health information.

D. Nothing in this section shall be construed to prevent an individual from disclosing that individual's own individually identifiable health information.

E. As used in this section, "individually identifiable health information" means information related to the provision of health care or public health services to an individual that:

(1) is directly related to diseases or a condition of public health importance; and

(2) can be used to identify the individual recipient of health care or public health services.

History: Laws 2017, ch. 87, § 20.

24-1-16. Inspection definitions.

As used in Sections 16 through 19 [24-1-16 to 24-1-19 NMSA 1978] of the Public Health Act:

A. "inspectorial search" means an entry into and examination of premises or vehicles, for the purpose of ascertaining the existence or nonexistence of conditions dangerous to health or safety or otherwise relevant to the public interest, in accordance with inspection requirements prescribed by fire, housing, sanitation, welfare, zoning or other laws or ordinances duly enacted for the promotion of public well-being;

B. "inspection officer" means an official authorized by law to conduct inspectorial searches; and

C. "inspection order" means an order issued by a magistrate or other competent official authorizing an inspectorial search.

History: 1953 Comp., § 12-34-16, enacted by Laws 1973, ch. 359, § 16.

24-1-17. Inspectorial search by consent.

A. Within the scope of his authority with respect to the places to be inspected and the purpose for which inspection is to be carried out, an inspection officer may conduct an inspectorial search, with the voluntary consent of an occupant or custodian of the premises or vehicles to be inspected, who reasonably appears to the inspection officer to be in control of the places to be inspected or otherwise authorized to give such consent.

B. Before requesting consent for an inspectorial search, the inspection officer shall inform the person to whom the request is directed of the authority under and purposes for which the inspection is to be made and shall, upon demand, exhibit a badge or document evidencing his authority to make such inspections.

C. Inspections undertaken pursuant to this section shall be carried out with due regard for the convenience and privacy of the occupants, and during the daytime unless, because of the nature of the premises, the convenience of the occupants or other circumstances, there is a reasonable basis for carrying out the inspection at night.

D. Except in accordance with the provisions of the subsequent subsection adequate notice of the time and purpose of an inspection shall be sent to the occupants or custodians of premises or vehicles to be inspected not less than seven days before the inspection is undertaken.

E. The notice required by the preceding subsection may be dispensed with if, because of the nature of the inspection to be undertaken, the conduct of the occupants, or other circumstances, there is a reasonable basis for belief that such notice would obstruct, or seriously diminish the utility, of the inspection in question.

History: 1953 Comp., § 12-34-17, enacted by Laws 1973, ch. 359, § 17.

24-1-18. Inspection searches.

A. Upon sufficient showing that consent to an inspectorial search has been refused or is otherwise unobtainable within a reasonable period of time, an inspection officer may make application for an inspection order. Such application shall be made to a district court judge having jurisdiction over the premises or vehicle to be searched or an administrative official authorized by statute or ordinance to issue inspection orders.

B. The application shall be granted and the inspection order issued upon a sufficient showing that inspection in the area in which the premises or vehicles in question are

located, or inspection of the particular premises or vehicles, is in accordance with reasonable legislative or administrative standards, and that the circumstances of the particular inspection for which application is made are otherwise reasonable. The issuing authority shall make and keep a record of the proceedings on the application, and enter thereon his finding in accordance with the requirements of this section.

C. The inspection officer executing the order shall, if the premises or vehicle in question are unoccupied at the time of execution, be authorized to use such force as is reasonably necessary to effect entry and make the inspection.

D. The officer conducting the search shall, if authorized by the issuing authority on proper showing, be accompanied by one or more law enforcement officers authorized to serve search warrants who shall assist the inspection officer in executing the order at his direction.

E. After execution of the order or after unsuccessful efforts to execute the order, as the case may be, the inspection officer shall return the order to the issuing authority with a sworn report of the circumstances of execution or failure thereof.

History: 1953 Comp., § 12-34-18, enacted by Laws 1973, ch. 359, § 18.

24-1-19. Emergency inspectorial searches.

A. Whenever it reasonably appears to an inspection officer that there may be a condition, arising under the laws he is authorized to enforce and imminently dangerous to health and safety, the detection or correction of which requires immediate access, without prior notice, to premises for purposes of inspectorial search, and if consent to such search is refused or cannot be promptly obtained, the inspection officer may make an emergency inspectorial search of the premises without an inspection order.

B. Upon completion of the emergency inspectorial search, the inspection officer shall make prompt report of the circumstances to the judicial or administrative authority to whom application for an inspection order would otherwise have been made.

History: 1953 Comp., § 12-34-19, enacted by Laws 1973, ch. 359, § 19.

24-1-20. Records confidential.

A. The files and records of the department giving identifying information about individuals who have received or are receiving from the department treatment, diagnostic services or preventive care for diseases, disabilities or physical injuries, are confidential and are not open to inspection except where permitted by rule of the department, as provided in Subsection C of this section and to the secretary of health and environment [secretary of health] or to an employee of the health and environment department [department of health] authorized by the secretary to obtain such information, but the information shall only be revealed for use in connection with a

governmental function of the secretary or the authorized employee. Both the secretary and the employees are subject to the penalty contained in Subsection F of this section if they release or use the information in violation of this section.

B. All information voluntarily provided to the director or his agent in connection with studies designated by him as medical research and approved by the secretary of health and environment [secretary of health], either conducted by or under the authority of the director for the purpose of reducing the morbidity or mortality from any cause or condition of health, is confidential and shall be used only for the purposes of medical research. The information shall not be admissible as evidence in any action of any kind in any court or before any administrative proceeding or other action.

C. The human services department [health care authority department] and the office of the state long-term care ombudsman shall have prompt access to all files and records in the possession of the licensing and certification bureau of the department that are related to any health facility investigation. Officers and employees of those agencies with such access are subject to the penalty in Subsection F of this section if they release or use the information in violation of this section.

D. The files and records of the department are subject to subpoena for use in any pending cause in any administrative proceeding or in any of the courts of the state, unless otherwise provided by law.

E. No person supplying information to the department for use in a research project or any cooperating person in a research project shall be subject to any action for damages or other relief as a result of that activity.

F. Any person who discloses confidential information in violation of this section is guilty of a petty misdemeanor.

History: 1953 Comp., § 12-34-20, enacted by Laws 1973, ch. 359, § 20; 1975, ch. 324, § 1; 1977, ch. 253, § 41; 1990, ch. 105, § 3.

24-1-21. Penalties.

Any person violating any of the provisions of the Public Health Act or any order, rule or regulation adopted pursuant to the provisions of the Public Health Act is guilty of a petty misdemeanor and shall be punished by a fine not to exceed one hundred dollars ($100) or imprisonment in the county jail for a definite term not to exceed six months or both such fine and imprisonment in the discretion of the court. Each day of a continuing violation of Subsection A of Section 24-1-5 NMSA 1978 after conviction shall be considered a separate offense. The department also may enforce its rules and orders by any appropriate civil action. The attorney general shall represent the department.

History: 1953 Comp., § 12-34-22, enacted by Laws 1973, ch. 359, § 22; 1975, ch. 183, § 4; 1983, ch. 185, § 2.

24-1-22. Scientific laboratory division; testing methods; certification.

A. The scientific laboratory division of the department of health is authorized to promulgate and approve satisfactory techniques or methods to test persons believed to be operating a motor vehicle or a motorboat under the influence of drugs or alcohol and to issue certification for test operators and their instructors that shall be subject to termination or revocation at the discretion of the scientific laboratory division. The scientific laboratory division is further authorized to establish or approve quality control measures for alcohol breath testing and to establish or approve standards of training necessary to ensure the qualifications of individuals conducting these analyses or collections.

B. The scientific laboratory division shall establish criteria and specifications for equipment, training, quality control, testing methodology, blood-breath relationships and the certification of operators, instructors and collectors of breath samples.

C. All laboratories analyzing breath, blood or urine samples pursuant to the provisions of the Implied Consent Act [66-8-105 to 66-8-112 NMSA 1978] and the Boating While Intoxicated Act [66-13-1 to 66-13-13 NMSA 1978] shall be certified by the scientific laboratory division. The certification shall be granted in accordance with the rules and regulations of the scientific laboratory division and shall be subject to termination or revocation for cause.

History: Laws 1981, ch. 165, § 1; 2003, ch. 241, § 14.

24-1-23. Recompiled.

History: Laws 1987, ch. 157, § 1; § 24-1-23, recompiled as § 24A-1-18 by Laws 2024, ch. 39, § 132.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1-23 NMSA 1978 as 24A-1-18 NMSA 1978, effective July 1, 2024.

24-1-24. Repealed.

History: Laws 1997, ch. 242, § 7 and Laws 1997, ch. 247, § 4; repealed by Laws 2013, ch. 44, § 3.

24-1-25. Holly Gonzales experimental treatment fund created.

A. The "Holly Gonzales experimental treatment fund" is created in the state treasury.

B. The Holly Gonzales experimental treatment fund shall be administered by the secretary of health. The money in the fund shall be used solely for the purpose of paying for the costs of federal drug administration approved experimental treatments or procedures for children with catastrophic, debilitating or terminal illnesses. An attending physician of a patient seeking coverage of a treatment or procedure from the fund shall certify to the secretary of health that conventional treatments or procedures cannot control or cure the illness, the expected outcome for the patient is death and the experimental treatment or procedure has a reasonable chance of either curing or controlling the illness for an extended period of time. The patient shall provide documentation from his medical insurer that the experimental treatment is not included in the policy covering the patient.

C. The patient shall submit receipts to the secretary of health for payment from the Holly Gonzales experimental treatment fund for the direct expenses of the experimental treatment or procedure and for associated expenses necessarily incurred in obtaining the treatment or procedure.

D. Disbursements from the Holly Gonzales experimental treatment fund shall be by warrant drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of health.

History: Laws 2001, ch. 333, § 1.

24-1-26. Repealed.

History: Laws 2003, ch. 59, § 1; repealed by Laws 2004, ch. 46, § 18.

24-1-27. Purpose.

The purpose of creating a single interagency behavioral health purchasing collaborative is to develop a statewide system of behavioral health care that promotes the behavioral health and well-being of children, individuals and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention and early intervention, resiliency, recovery and rehabilitation.

History: Laws 2004, ch. 46, § 1.

24-1-28. Recompiled.

History: Laws 2004, ch. 46, § 2; 2005, ch. 7, § 1; § 24-1-28, recompiled and amended as § 24A-3-2 by Laws 2024, ch. 39, § 44.

24-1-29. Commission created; members; duties.

A. There is created the "governor's HIV and AIDS policy commission", consisting of twenty-three members as follows:

(1) the secretary of health or the secretary's designee;

(2) the secretary of human services or the secretary's designee;

(3) the secretary of public education or the secretary's designee;

(4) the chief medical officer of the corrections department or the officer's designee;

(5) the chair of the department of health's medical advisory committee;

(6) the executive director of the New Mexico medical insurance pool or the director's designee;

(7) a representative from each of the six health management alliance organizations, appointed by the governor;

(8) six consumers reflecting the diversity of the HIV and AIDS populations in New Mexico, including Native Americans and other people of color, appointed by the governor; and

(9) five public members who have expertise in HIV and AIDS services, prevention, program administration, financial management and other categories of expertise required under federal planning requirements, appointed by the governor.

B. The governor shall appoint the chair of the commission. Members appointed by the governor shall serve for terms of three years, except that the initial term of seven members shall be two years. Vacancies of the appointed members shall be filled by appointment by the governor for the remainder of the unexpired term. Appointed members shall receive per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] but shall receive no other compensation, perquisite or allowance. The commission shall be administratively attached to the department, which shall provide administrative services to the commission.

C. The commission shall:

(1) review and make recommendations on department HIV and AIDS policies;

(2) study and make recommendations to the department on all factors affecting the availability, quality and accessibility of health services for persons with HIV and AIDS, including:

(a) review and consult with the department's medical advisory committee regarding the HIV and AIDS drug formulary and policies of selection, utilization and provision of those drugs; and

(b) review policies and practices of each state agency with responsibilities to persons with HIV and AIDS, including statutes and rules governing these responsibilities;

(3) serve as a planning and advisory group to the department's HIV and AIDS services program;

(4) annually provide its evaluation and recommendations to the department for inclusion in the department's annual report, including recommendations for administrative and legislative changes, for resource allocation by the department and for funding;

(5) provide information on HIV and AIDS programs and issues as requested by the executive and legislative branches of government;

(6) advocate for improved and expanded services for persons living with HIV and AIDS; and

(7) establish task forces as it deems necessary.

D. For purposes of this section:

(1) "commission" means the governor's HIV and AIDS policy commission;

(2) "department" means the department of health;

(3) "HIV and AIDS" means human immunodeficiency virus and acquired immune deficiency syndrome; and

(4) "consumers" means people living with HIV and AIDS.

History: Laws 2005, ch. 5, § 1.

24-1-30. Hand washing facilities; requirement.

Portable hand washing facilities shall be provided with at least one hand wash facility to every one-to-ten portable toilets in public locations where portable toilets are required by law or ordinance. The facilities shall be in close proximity to the toilets.

History: Laws 2005, ch. 190, § 1.

24-1-31. Save our children's sight fund created.

The "save our children's sight fund" is created in the state treasury. Money in the fund shall consist of appropriations, contributions, grants and statutory revenues directed to the fund. Money in the fund is appropriated to the department of health, which shall administer the fund for the purpose of development and implementation of a vision screening program making vision screenings and follow-up comprehensive examinations available to New Mexico children regardless of family income. Expenditures from the fund shall be by warrants of the secretary of finance and administration drawn pursuant to vouchers signed by the secretary of health or the secretary's authorized representative. Money in the fund shall not revert at the end of a fiscal year.

History: Laws 2007, ch. 353, § 1 and Laws 2007, ch. 357, § 1.

24-1-32. Notice of the need for further vision evaluation and availability of funds.

The department of health shall promulgate rules for award of money from the save our children's sight fund. When the vision screen of a student indicates the need for further evaluation, the student's school shall notify the student's parent of that need and provide information on the availability of funds from the save our children's sight fund. The notice shall state that the parent, if the student is not already covered by health insurance for a comprehensive eye examination, may apply to the fund for the following expenses as a result of the screening:

A. a comprehensive eye examination by an optometrist or ophthalmologist whose services are used to follow up the school vision screen;

B. the cost of contact lenses or polycarbonate lenses and frames for eyeglasses; and

C. replacement insurance for lost or broken lenses.

History: Laws 2007, ch. 353, § 3 and Laws 2007, ch. 357, § 3.

24-1-33. Communication regarding reconstructive breast surgery.

A. A health care provider that provides mastectomy or lumpectomy or lymph node dissection surgery of the breast shall provide information to the patient about the option of reconstructive surgery. The information shall be provided to the patient in writing and in advance of obtaining consent for the mastectomy or lumpectomy or lymph node dissection surgery of the breast. The information shall include at least a description of:

(1) reconstructive surgery options and the advantages and disadvantages of each option;

(2) the availability of health insurance or health care coverage for costs related to reconstructive surgery pursuant to the New Mexico Insurance Code [Chapter 59A NMSA 1978, except for Articles 30A and 42A] and the federal Women's Health and Cancer Rights Act of 1998; and

(3) patient access to reconstructive surgery services, including referring the patient to a health care provider that provides reconstructive surgery if the health care provider that performs the mastectomy or lumpectomy or lymph node dissection surgery of the breast does not offer reconstructive surgery services.

B. The department of health shall notify health care providers of the provisions of Subsection A of this section.

History: Laws 2011, ch. 145, § 1.

24-1-34. Recompiled.

History: Laws 2012, ch. 4, § 1; 2015, ch. 90, § 1; § 24-1-34, recompiled and amended as § 24A-1-15 by Laws 2024, ch. 39, § 36.

24-1-35. Recompiled.

History: Laws 2013, ch. 114, § 1; § 24-1-35, recompiled and amended as § 24A-1-16 by Laws 2024, ch. 39, § 37.

24-1-36. Statewide community-based adult fall risk awareness and prevention program.

A. By January 1, 2015, the department of health shall establish a statewide community-based adult fall risk awareness and prevention program.

B. In implementing the statewide community-based adult fall risk awareness and prevention program, the department of health shall:

(1) contract for the development of a culturally competent and literacy level-appropriate statewide community-based adult fall risk awareness and prevention media campaign, to include a web page, a referral clearinghouse and statewide media placement of print, radio and television messages;

(2) conduct program outreach to the public, to groups or to organizations that advocate for adult fall risk awareness and prevention and to health care providers;

(3) arrange for and coordinate adult fall risk awareness and prevention training and workshops;

(4) serve as a resource for information and written materials on adult fall risk awareness and prevention;

(5) act as a liaison between the New Mexico healthy aging collaborative, the New Mexico older adult falls prevention coalition, groups or organizations that advocate for adult fall risk awareness and prevention and sources of funding for adult fall risk awareness and prevention programming and activities;

(6) contract with one or more universities, colleges or other institutions of higher learning to provide educational programming in evidence-based fall risk assessment and fall prevention strategies;

(7) contract with one or more area agencies on aging, community hospitals, the federal Indian health service, tribally operated 638 health programs or urban Indian health programs to provide fall risk awareness and prevention programming and literature to the public;

(8) conduct trainer instructional workshops and booster training for evidence-based fall risk awareness and prevention programs; and

(9) contract with one or more senior centers, community centers, parks and recreation departments or other local, county, municipal or tribal organizations providing services to senior citizens to implement evidence-based interventions for adult fall prevention.

History: Laws 2014, ch. 37, § 1.

24-1-37. Recompiled.

History: Laws 2015, ch. 155, § 1; § 24-1-37, recompiled and amended as § 24A-1-11 by Laws 2024, ch. 39, § 32.

24-1-38. Hospitals; requirement to offer influenza and pneumococcal immunizations.

Each year between October 1 and March 1 and in accordance with the latest recommendations of the advisory committee on immunization practices of the federal centers for disease control and prevention, each hospital licensed by the department of health shall offer, prior to discharge, immunizations against the influenza virus and pneumococcal disease to all inpatients sixty-five years of age and older unless contraindicated for a patient and contingent upon the availability of the vaccine.

History: Laws 2017, ch. 51, § 1.

24-1-39. Recompiled.

History: Laws 2019, ch. 4, § 1; § 24-1-39, recompiled as § 24A-1-19 by Laws 2024, ch. 39, § 132.

24-1-40. Department of health; New Mexico board of dental health care; annual report; biennial report.

The department of health shall collaborate with the New Mexico board of dental health care and provide to the legislative health and human services committee and the legislative finance committee the following reports:

A. by October 1, 2020 and by each October 1 thereafter, a report relating to access to dental health care. The department shall compile for the report at least the following information with analysis and recommendations for legislative action relating to this information:

(1) the status of dental health care professional education loan-for-service programming;

(2) the feasibility of establishing a program allowing bachelor of arts degree recipients to matriculate directly to dental school for a doctor of dental medicine or doctor of dental surgery degree;

(3) the status of the state's medicaid program, including:

(a) simplification of administrative procedures regarding the provision of dental health care to medicaid recipients; and

(b) changes to reimbursement levels that would encourage dental health care professionals to accept more medicaid recipients as patients;

(4) the number of dental health care professionals taking advantage of the rural health care practitioner tax credit;

(5) other timely issues as determined by the New Mexico board of dental health care to have an impact on access to or the delivery of dental health care in New Mexico; and

(6) the identification of activities in the dental therapist's scope of practice that require dental therapy post-graduate clinical experience; and

B. by October 1, 2020 and by October 1 every two years thereafter, a report on the status of the dental therapist licensure program, including the:

(1) name and number of educational institutions offering accreditation of a dental therapy educational program;

(2) number of students enrolled in each dental therapy educational program, per educational institution;

(3) number of licensed dental hygienists enrolled in dental therapy educational programs, per educational institution;

(4) number of students who have graduated from dental therapy educational programs;

(5) name and number of locations where students are completing dental therapy post-graduate experience;

(6) number of graduates practicing under general supervision;

(7) practice location for all licensed dental therapists in the state, by county; and

(8) number of dental therapists in each county.

History: Laws 2019, ch. 107, § 12.

24-1-41. Recompiled.

History: Laws 2019, ch. 129, § 1; § 24-1-41, recompiled and amended as § 24A-1-13 by Laws 2024, ch. 39, § 34.

24-1-42. Recompiled.

History: Laws 2021, ch. 127, § 1; § 24-1-42, recompiled as § 24A-1-20 by Laws 2024, ch. 39, § 132.

24-1-43. Reporting; medical aid in dying.

A. A health care provider who prescribes medical aid in dying to a qualified individual in accordance with the provisions of the End-of-Life Options Act [24-7C-1 to 24-7C-8 NMSA 1978] shall provide, in accordance with department rules, a report of that provider's participation. The department shall adopt and promulgate rules that establish the time frames and forms for reporting pursuant to this section and shall limit the reporting of data relating to qualified individuals who received prescriptions for medical aid in dying medication to the following:

(1) the qualified individual's age at death;

(2) the qualified individual's race and ethnicity;

(3) the qualified individual's gender;

(4) whether the qualified individual was enrolled in hospice at the time of death;

(5) the qualified individual's underlying medical condition; and

(6) whether the qualified individual self-administered the medical aid in dying medication and, if so, the date that this occurred.

B. The department shall promulgate an annual statistical report, containing aggregated data, on the information collected pursuant to Subsection A of this section on the total number of medical aid in dying medication prescriptions written statewide and on the number of health care providers who have issued prescriptions for medical aid in dying medication during that year. Data reported pursuant to this subsection shall not contain individually identifiable health information and are exempt from disclosure pursuant to the Inspection of Public Records Act [Chapter 14, Article 3 NMSA 1978].

C. As used in this section:

(1) "health care provider" means an individual authorized pursuant to the End-of-Life Options Act to prescribe medical aid in dying;

(2) "medical aid in dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to end that individual's life in accordance with the provisions of the End-of-Life Options Act; and

(3) "qualified individual" means an individual who has met the requirements to receive medical aid in dying pursuant to the provisions of the End-of-Life Options Act.

History: Laws 2021, ch. 132, § 9.

24-1-44. School-based health centers; creation and operation.

A. The department shall provide funding, technical assistance, clinical oversight and other necessary support for the creation and operation of school-based health centers.

B. School-based health centers receiving funding from the department shall be regulated by the department to provide services pursuant to Subsection E of this section.

C. School-based health centers shall be established in schools, within the boundaries of school campuses or within safe walking distances from school campuses as determined by the school and the school-based health center operator, in communities based on:

(1) need for services;

(2) operator availability; and

(3) support from local educational authorities.

D. School-based health centers shall work in cooperation with schools and school districts and be operated by licensed health care providers, including hospitals, federally qualified health centers, the department's public health nurses and other qualified health care providers.

E. School-based health centers shall provide services through licensed providers, including:

(1) primary health care;

(2) preventive health care, including comprehensive health assessments and diagnosis;

(3) treatment of minor, acute and chronic conditions;

(4) mental health care;

(5) substance use disorder assessments, treatment and referral;

(6) crisis intervention; or

(7) referrals as necessary for additional treatment, including inpatient care, specialty care, emergency psychiatric care, oral health care and vision health care services.

F. The department shall adopt and promulgate rules for the regulation, operation and oversight of school-based health centers receiving funding from the department.

G. For purposes of this section:

(1) "department" means the department of health;

(2) "mental health care" means services related to emotional, psychological and social well-being;

(3) "preventive health care" means services that include screenings, checkups and patient counseling to stop or slow the progression of illness, diseases and other health problems; and

(4) "primary health care" means health care services that include providing preventive care, promoting wellness and treating common illnesses.

History: Laws 2023, ch. 48, § 1.

ARTICLE 1A
Rural Primary Health Care

24-1A-1. Short title.

This act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978] may be cited as the "Rural Primary Health Care Act".

History: Laws 1981, ch. 295, § 1.

24-1A-2. Purpose of act.

The purpose of the Rural Primary Health Care Act is to recruit and retain health care personnel and assist in the provision of primary health care services through eligible programs in underserved areas of the state in order to better serve the health needs of the public.

History: Laws 1981, ch. 295, § 2; 1983, ch. 236, § 1.

24-1A-3. Definitions.

As used in the Rural Primary Health Care Act:

A. "health care underserved areas" means a geographic area in which it has been determined by the department of health, through the use of indices and other standards set by the department, that sufficient primary health care is not being provided to the citizens of that area;

B. "eligible programs" means nonprofit community-based entities that provide or commit to provide primary health care services for residents of health care underserved areas and includes rural health facilities and those serving primarily low-income populations;

C. "department" means the department of health; and

D. "primary health care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services.

History: Laws 1981, ch. 295, § 3; 1983, ch. 236, § 2; 1996, ch. 29, § 2.

24-1A-3.1. Department; technical and financial assistance.

To the extent funds are made available for the purposes of the Rural Primary Health Care Act, the department is authorized to:

A. provide for a program to recruit and retain health care personnel in health care underserved areas;

B. develop plans for and coordinate the efforts of other public and private entities assisting in the provision of primary health care services through eligible programs;

C. provide for technical assistance to eligible programs in the areas of administrative and financial management, clinical services, outreach and planning;

D. provide for distribution of financial assistance to eligible programs that have applied for and demonstrated a need for assistance in order to sustain a minimum level of delivery of primary health care services; and

E. provide a program for enabling the development of new primary care health care services or facilities, and that program:

(1) shall give preference to communities that have few or no community-based primary care services;

(2) may require in-kind support from local communities where primary care health care services or facilities are established;

(3) may require primary care health care services or facilities to assure provision of health care to the medically indigent; and

(4) shall permit the implementation of innovative and creative uses of local or statewide health care resources, or both, other than those listed in Paragraphs (2) and (3) of this subsection.

History: 1978 Comp., § 24-1A-3.1, enacted by Laws 1983, ch. 236, § 3; 1991, ch. 212, § 18; 1996, ch. 29, § 3.

24-1A-4. Rules and regulations.

Subject to the State Rules Act [Chapter 14, Article 4 NMSA 1978], the department shall adopt rules and regulations for recruiting health care personnel in health care underserved areas, and shall establish a formula for distribution of financial assistance to eligible programs which shall take into account the relative needs of applicants for assistance, provided that funds may not be expended for land or facility acquisition or debt amortization and further provided that a local match of ten percent shall be required from each local recipient for each request for assistance.

History: Laws 1981, ch. 295, § 4; 1983, ch. 236, § 4.

24-1A-5. Repealed.

History: Laws 2023, ch. 204, § 1; § 24-1A-5, repealed by Laws 2024, ch. 39, § 133.

ARTICLE 1B
Maternal and Child Health Plan (Repealed.)

24-1B-1. Repealed.

History: Laws 1991, ch. 113, § 1; 2007, ch. 94, § 1; repealed by Laws 2019, ch. 57, § 7.

24-1B-2. Repealed.

History: Laws 1991, ch. 113, § 2; 2007, ch. 94, § 2; repealed by Laws 2019, ch. 57, § 7.

24-1B-3. Repealed.

History: Laws 1991, ch. 113, § 3; 2007, ch. 94, § 3; repealed by Laws 2019, ch. 57, § 7.

24-1B-4. Repealed.

History: Laws 1991, ch. 113, § 4; 2007, ch. 94, § 4; repealed by Laws 2019, ch. 57, § 7.

24-1B-5. Repealed.

History: Laws 1991, ch. 113, § 5; 2007, ch. 94, § 5; repealed by Laws 2019, ch. 57, § 7.

24-1B-6. Repealed.

History: Laws 1991, ch. 113, § 6; 2007, ch. 94, § 6; repealed by Laws 2019, ch. 57, § 7.

24-1B-7. Repealed.

History: Laws 1991, ch. 113, § 7; 2007, ch. 94, § 7; repealed by Laws 2019, ch. 57, § 7.

ARTICLE 1C
Primary Care Capital Funding

24-1C-1. Short title.

Chapter 24, Article 1C NMSA 1978 may be cited as the "Primary Care Capital Funding Act".

History: Laws 1994, ch. 62, § 7; 1997, ch. 230, § 1.

24-1C-2. Purpose.

The purpose of the Primary Care Capital Funding Act is to provide funding for capital projects to eligible entities in order to increase health care services in rural and other health care underserved areas in the state.

History: Laws 1994, ch. 62, § 8.

24-1C-3. Definitions.

As used in the Primary Care Capital Funding Act:

A. "authority" means the New Mexico finance authority;

B. "capital project" means acquisition, repair, renovation or construction of a facility; purchase of land; acquisition of capital equipment of a long-term nature; or acquisition of capital equipment to be used in the delivery of primary care, telehealth or hospice services;

C. "department" means the department of health;

D. "eligible entity" means:

(1) a community-based nonprofit primary care clinic or hospice that operates in a rural or other health care underserved area of the state, that is a 501(c)(3) nonprofit corporation for federal income tax purposes and that is eligible for funding pursuant to the Rural Primary Health Care Act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978];

(2) a school-based health center that operates in a public school district and that meets department requirements or that is funded by the federal department of health and human services;

(3) a primary care clinic that operates in a rural or other health care underserved area of the state, that is owned by a county or municipality and that meets department requirements for eligibility; or

(4) a telehealth site that is operated by an entity described in this subsection;

E. "fund" means the primary care capital fund;

F. "operating capital" means funds needed to meet short-term obligations, such as accounts payable, wages, debt servicing, lease and income tax payments;

G. "primary care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services and including services delivered at a primary care clinic, a telehealth site or a school-based health center; "primary care" includes the provision of mental health services if those services are integrated into the eligible entity's service array; and

H. "project" means a capital project or operating capital needed to support the increase of primary care services to sick and medically indigent persons.

History: Laws 1994, ch. 62, § 9; 2000, ch. 75, § 1; 2005, ch. 54, § 1; 2019, ch. 276, § 1; 2023, ch. 129, § 6.

24-1C-4. Primary care capital fund; creation.

A. The "primary care capital fund" is created as a revolving fund in the authority. The fund shall consist of appropriations, loan repayments, gifts, grants, donations and interest earned on investment of the fund. A separate account shall be maintained for appropriations, loan repayments, gifts, grants, donations and interest earned on investment of the account for loans to school-based health centers and telehealth sites. Money in the fund shall not revert at the end of a fiscal year.

B. The fund shall be administered by the authority. The authority may recover from the fund the actual costs of administering the fund and originating loans..

History: Laws 1994, ch. 62, § 10; 2005, ch. 54, § 2; 2019, ch. 276, § 2; 2023, ch. 129, § 7.

24-1C-5. Rules.

The authority shall adopt rules to administer and implement the provisions of the Primary Care Capital Funding Act, including providing for:

A. the determination of rural or other health care underserved areas of the state in which eligible entities may receive loans or contracts for services from the fund;

B. procedures and forms for applying for loans or contracts for services for projects;

C. documentation required to be provided by the applicant to justify the need for the project;

D. documentation required to be provided by the applicant to demonstrate that the applicant is an eligible entity;

E. procedures for review, evaluation and approval of loans and contracts for services, including the programmatic, organizational and financial information necessary to review, evaluate and approve an application;

F. evaluation of the ability and competence of an applicant to provide efficiently and adequately for the completion of a proposed project;

G. approval of loan and contract for services applications, including provisions that accord priority attention to areas with the greatest need for primary care services;

H. fair geographic distribution of loans and contracts for services; and

I. such other requirements deemed necessary by the department to ensure that the state receives the primary care services for which the legislature appropriates money and that protect the state's interest in a project.

History: Laws 1994, ch. 62, § 11; 2023, ch. 129, § 8.

24-1C-6. Department; authority; powers and duties.

A. The department and the authority shall administer the loan programs and contracts for services established pursuant to the provisions of the Primary Care Capital Funding Act. The department and authority shall:

(1) enter into joint powers agreements with each other or other appropriate public agencies to carry out the provisions of that act; and

(2) apply to any appropriate federal, state or local governmental agency or private organization for grants and gifts to carry out the provisions of that act or to fund allied community-based health care programs.

B. The department or authority may, instead of a loan, contract for services with an eligible entity to provide free or reduced fee primary care services for sick and medically indigent persons as reasonably adequate legal consideration for money from the fund to the entity so it may acquire or construct a capital project to provide the services.

C. The department and authority may:

(1) make and enter into contracts and agreements necessary to carry out their powers and duties pursuant to the provisions of the Primary Care Capital Funding Act; and

(2) do all things necessary or appropriate to carry out the provisions of the Primary Care Capital Funding Act.

D. The authority is responsible for all financial duties of the programs, including:

(1) administering the fund;

(2) accounting for all money received, controlled or disbursed for capital projects in accordance with the provisions of the Primary Care Capital Funding Act;

(3) evaluating and approving loans and contracts for services, including determining financial capacity of an eligible entity;

(4) enforcing contract provisions of loans and contracts for services, including the ability to sue to recover money or property owed the state;

(5) determining requirements for repayment of loans, including interest rates, loan terms, payment schedules and other financial aspects of a loan and relevant terms of a contract for services;

(6) ensuring the authority's interest in any project by the filing of a lien equal to the total of the authority's financial participation in the project; and

(7) performing other duties in accordance with the provisions of the Primary Care Capital Funding Act, rules promulgated pursuant to that act or joint powers agreements entered into with the department.

E. The department is responsible for the following duties:

(1) defining sick and medically indigent persons for purposes of the Primary Care Capital Funding Act;

(2) establishing priorities for loans and contracts for services;

(3) determining the appropriateness of the project;

(4) evaluating the capability of an applicant to provide and maintain primary care or hospice services;

(5) selecting recipients of loans and persons with whom to contract for services;

(6) determining that capital projects comply with all state and federal licensing; and

(7) contracting with an eligible entity to provide primary care services without charge or at a reduced fee for sick and medically indigent persons as defined by the department.

F. The authority may make a loan to an eligible entity to acquire, construct, renovate or otherwise improve a capital project or to fund operating capital, provided there is a finding:

(1) by the department that the project will provide primary care services to sick and medically indigent persons as defined by the department; and

(2) by the authority that there is adequate protection, including loan guarantees, real property liens, title insurance, security interests in or pledges of accounts and other assets, loan covenants and warranties or restrictions on other encumbrances and pledges for the state funds extended for the loan.

G. The authority may make a loan to a school-based health center that operates in a school district or to a telehealth site for a capital project; provided, however, that the loan shall not exceed the amount in the account reserved for school-based health center or telehealth site funding.

History: Laws 1994, ch. 62, § 12; 1997, ch. 230, § 2; 2005, ch. 54, § 3; 2023, ch. 129, § 9.

24-1C-7, 24-1C-8. Repealed.

24-1C-9. Eligible entity; change in status.

If an eligible entity that has received a loan or contract for services for a capital project ceases to maintain its nonprofit status or ceases to deliver primary care services at the site of the capital project for twelve consecutive months, the authority may pursue the remedies provided in the loan agreement or contract for services or as provided by law.

History: Laws 1994, ch. 62, § 15; 1997, ch. 230, § 3; 2023, ch. 129, § 10.

24-1C-10. Report.

The department and the authority shall report jointly to the governor and the legislature by December 1 of each year on the primary care capital funding program.

History: Laws 1994, ch. 62, § 16.

ARTICLE 1D
Health Service Corps

24-1D-1. Short title.

This act [24-1D-1 to 24-1D-10 NMSA 1978] may be cited as the "Health Service Corps Act".

History: Laws 1994, ch. 63, § 1.

24-1D-2. Definitions.

As used in the Health Service Corps Act:

A. "corps" means the New Mexico health service corps;

B. "department" means the department of health;

C. "health professional" means a physician, physician assistant, nurse practitioner, nurse-midwife, emergency medical technician-paramedic, dentist or dental hygienist;

D. "physician" means a medical doctor or doctor of osteopathic medicine;

E. "physician assistant" means a physician assistant or osteopathic physician assistant; and

F. "practice site" means a public health clinic or public or private nonprofit primary care clinic that is located in a state-designated medically underserved area or that serves a high-needs population and that uses a sliding fee scale approved by the department.

History: Laws 1994, ch. 63, § 2; 2003, ch. 393, § 1.

24-1D-3. New Mexico health service corps; staff; department powers and duties.

A. The "New Mexico health service corps" is created in the department to recruit and place health professionals in rural and other medically underserved areas. The secretary of health may employ a medical director to head the corps. The medical director may employ support staff and employ or contract with health professional staff. Employees are subject to the provisions of the Personnel Act [Chapter 10, Article 9 NMSA 1978].

B. The corps has the power to:

(1) enter into contracts to carry out the provisions of the Health Service Corps Act and sue for enforcement of those contracts; and

(2) adopt and file, in accordance with the State Rules Act [Chapter 14, Article 4 NMSA 1978], rules and regulations to carry out the provisions of the Health Service Corps Act.

C. The corps shall:

(1) recruit health professionals as employees or contractors of the corps;

(2) determine physician specialties to be recruited, with a focus on family practice physicians;

(3) establish criteria and procedures for the acceptance of applications and selection of recipients for commitment stipends;

(4) establish criteria and procedures for evaluating and qualifying corps health professionals;

(5) determine and maintain a list of eligible communities and practice sites;

(6) determine the need for health professionals at each practice site and assign staff as needed on a priority basis;

(7) provide support for health professionals at practice sites;

(8) work closely with the commission on higher education and the educational assistance foundation to coordinate the use of health professionals who have practice obligations pursuant to the Medical Student Loan for Service Act [Chapter 21, Article 22 NMSA 1978], the Osteopathic Medical Student Loan for Service Act [Chapter 21, Article 22A NMSA 1978] or the Nursing Student Loan for Service Act [Chapter 21, Article 22B NMSA 1978];

(9) work with the university of New Mexico school of medicine, college of nursing, the emergency medical services academy and any other entity to identify students or residents who qualify for the corps; and

(10) establish accounting and auditing procedures to account for all money paid to health professionals or received from communities and practice sites.

History: Laws 1994, ch. 63, § 3.

24-1D-4. Corps sites; local assistance; reimbursements.

The corps may require a community or practice site to pay the costs associated with providing corps health professionals in the community. The corps may allow in-kind contributions as partial or complete payment. The corps may negotiate with the community on the amount of money or in-kind services that shall be paid to the state.

Money paid to the state shall be deposited in the general fund. Payback requirements and in-kind contributions shall be determined and negotiated based on formulas adopted pursuant to regulations.

History: Laws 1994, ch. 63, § 4.

24-1D-5. Corps service; commitment stipends.

A. The corps may provide commitment stipends to potential health professionals who agree to serve in the corps for at least two years. Commitment stipends shall be determined by the department within available revenue.

B. Nothing in the Health Service Corps Act prohibits the corps from hiring health professionals who have not received commitment stipends.

History: Laws 1994, ch. 63, § 5.

24-1D-6. Evaluations prior to corps service; stipend payback.

A. All corps health professionals shall be licensed or certified to practice in New Mexico. If the corps determines that a person does not meet the corps' standards for service, that person shall not serve as a corps health professional.

B. Prior to service, the corps shall evaluate every student and resident to whom commitment stipends have been paid. Evaluations shall continue during service. Evaluations shall include grades; licensing test scores; recommendations of professors, professional mentors and co-workers; and other factors the corps determines by regulation to be pertinent to ensuring the provision of quality health care through the corps.

C. If a person to whom a commitment stipend has been paid does not qualify for service, he shall pay back the total stipend on terms and conditions set forth in the contract with the corps. If a person to whom a commitment stipend has been paid is serving in the corps and he is deemed unsatisfactory, he shall pay back the amount of stipend determined by formula to be owed pursuant to terms and conditions set forth in the contract with the corps.

D. If a person to whom a commitment stipend has been paid qualifies for service, he may pay back the stipend through service in a community specified by the department under conditions approved by the department even if he is not an employee or contractor of the corps.

History: Laws 1994, ch. 63, § 6.

24-1D-7. Corps service for educational loan-for-service programs.

Service in the corps may be used to satisfy service requirements pursuant to the provisions of state educational loan-for-service programs.

History: Laws 1994, ch. 63, § 7.

24-1D-8. Administrative assistance.

The corps may contract with other agencies to assist it in paying stipends and collecting money owed pursuant to contract provisions or penalties.

History: Laws 1994, ch. 63, § 8.

24-1D-9. Legal counsel.

The office of general counsel of the department of health shall provide legal services to the corps. The general form of stipend contracts entered into pursuant to the provisions of the Health Service Corps Act shall be approved by a special assistant attorney general employed by the department of health and signed by the resident or student and the medical director or his authorized representative on behalf of the state. The corps is vested with full and complete authority and power to sue in its own name for any balance due the state from a resident or student on a contract. Money paid pursuant to contract shall be deposited in the general fund.

History: Laws 1994, ch. 63, § 9.

24-1D-10. Failure to serve; penalty.

If a health professional whom the corps deems qualified to serve does not serve or serves only a portion of his service obligation, he is subject to a penalty of three times the amount of the total commitment stipend, plus eighteen percent interest per year. The corps shall provide by regulation for mitigating circumstances, the assessment of the penalty and payback schedules.

History: Laws 1994, ch. 63, § 10.

ARTICLE 1E
Health Facility Receiverships (Recompiled.)

24-1E-1. Recompiled.

History: 1978 Comp., § 24-1E-1, enacted by Laws 1996, ch. 35, § 4; 2001, ch. 225, § 1; recompiled and amended as § 24A-2-1 by Laws 2024, ch. 39, § 39.

24-1E-2. Recompiled.

History: 1978 Comp., § 24-1E-2, enacted by Laws 1996, ch. 35, § 5; 2001, ch. 225, § 2; recompiled and amended as § 24A-2-2 by Laws 2024, ch. 39, § 40.

24-1E-3. Recompiled.

History: 1978 Comp., § 24-1E-3, enacted by Laws 1996, ch. 35, § 6; recompiled and amended as § 24A-2-3 by Laws 2024, ch. 39, § 41.

24-1E-3.1. Recompiled.

History: Laws 2001, ch. 225, § 4; § 24-1E-3.1, recompiled and amended as § 24A-2-4 by Laws 2024, ch. 39, § 42.

24-1E-4. Recompiled.

History: 1978 Comp., § 24-1E-4, enacted by Laws 1996, ch. 35, § 7; 2001, ch. 225, § 3; recompiled as § 24A-2-5 by Laws 2024, ch. 39, § 132.

24-1E-5. Recompiled.

History: 1978 Comp., § 24-1E-5, enacted by Laws 1996, ch. 35, § 8; 2007, ch. 58, § 1; recompiled as § 24A-2-6 by Laws 2024, ch. 39, § 132.

24-1E-6. Recompiled.

History: 1978 Comp., § 24-1E-6, enacted by Laws 1996, ch. 35, § 9; recompiled as § 24A-2-7 by Laws 2024, ch. 39, § 132.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1E-6 NMSA 1978 as 24A-2-7 NMSA 1978, effective July 1, 2024.

24-1E-7. Recompiled.

History: Laws 2001, ch. 225, § 5; § 24-1E-7, recompiled as § 24A-2-8 by Laws 2024, ch. 39, § 132.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1E-7 NMSA 1978 as 24A-2-8 NMSA 1978, effective July 1, 2024.

ARTICLE 1F
Billy Griego HIV and AIDS Act

24-1F-1. Short title.

This act [24-1F-1 to 24-1F-6 NMSA 1978] may be cited as the "Billy Griego HIV and AIDS Act".

History: Laws 2005, ch. 6, § 1.

24-1F-2. Purpose.

The purpose of the Billy Griego HIV and AIDS Act is to ensure that consumers are the focus of the funding and services provided and their consideration is to be the determining factor in all the state's human immunodeficiency virus and acquired immune deficiency syndrome programs.

History: Laws 2005, ch. 6, § 2.

24-1F-3. Department of health; duties.

The department of health shall serve as the state's human immunodeficiency virus and acquired immune deficiency syndrome service coordinator among all state agencies, providing direct and contract education and prevention and treatment services for eligible persons, subject to the availability of funds. The department shall serve as the state contract administrator for federal Ryan White services funding as well as for all federal centers for disease control and prevention human immunodeficiency virus and acquired immune deficiency syndrome programs. Services shall include prevention, clinical services, a drug assistance and insurance assistance program to eligible individuals and programs appropriate for Native Americans, including traditional medicine services. Services shall be delivered in a consumer-oriented model. The department of health shall include a quality assurance component in all services and shall ensure that all clients are educated about their rights and responsibilities and the department's grievance procedures.

History: Laws 2005, ch. 6, § 3.

24-1F-4. Medical advisory committee created; membership; duties.

A. There is created at the department of health a "medical advisory committee" to consist of seven members, chaired by the department's chief medical officer or the officer's designee. Committee membership shall consist of four physicians and two consumers with current experience in the treatment of human immunodeficiency virus and acquired immune deficiency syndrome.

B. The committee shall review the department of health's human immunodeficiency virus and acquired immune deficiency syndrome drug formulary and policies regarding selection, utilization and provision of those drugs and recommend changes as appropriate to the department of health and report its recommendations to the governor's HIV and AIDS policy commission.

History: Laws 2005, ch. 6, § 4.

24-1F-5. Independent constituent service program; duties.

An independent "constituent services program" is created. The program shall review all fiscal matters and record and review all complaints and requests for services that come to its attention about public programs and services for persons living with the human immunodeficiency virus and acquired immune deficiency syndrome statewide. The program shall make an annual report to the department of health by November 1 of each year on its activities and recommendations.

History: Laws 2005, ch. 6, § 5.

24-1F-6. Annual report; policies and procedures.

A. The department of health shall provide an annual report on activities and expenditures conducted pursuant to the Billy Griego HIV and AIDS Act. The report shall be submitted no later than December 15 to the legislature and the governor.

B. The department of health shall develop and annually review policies and procedures pertaining to the Billy Griego HIV and AIDS Act.

History: Laws 2005, ch. 6, § 6.

ARTICLE 1G
New Mexico Telehealth and Health Information Technology Commission

24-1G-1. Repealed.

History: Laws 2005, ch. 55, § 1; 2007, ch. 14, § 1; § 24-1G-1, repealed by Laws 2024, ch. 39, § 133.

24-1G-2. Repealed.

History: Laws 2005, ch. 55, § 2; 2007, ch. 14, § 2; § 24-1G-2, repealed by Laws 2024, ch. 39, § 133.

24-1G-3. Definitions.

As used in the New Mexico Telehealth and Health Information Technology Commission Act:

A. "commission" means the New Mexico telehealth and health information technology commission;

B. "health information technology" means products, devices or systems that allow for the secure electronic collection, storage, exchange or management of patient information; and

C. "telehealth" means the use of electronic information, imaging and communication technologies, including interactive audio, video and data communications as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education.

History: Laws 2005, ch. 55, § 3; 2007, ch. 14, § 3.

24-1G-4. New Mexico telehealth and health information technology commission created; powers and duties; membership.

A. The "New Mexico telehealth and health information technology commission" is created. The commission is administratively attached to the department of health, which shall work in conjunction with the New Mexico health policy commission, in accordance with the Executive Reorganization Act [9-1-1 to 9-1-10 NMSA 1978].

B. The commission shall consist of no more than twenty-five members with members, one-third of whom shall be from rural areas, chosen from the following categories, all of whom shall be appointed by and serve at the pleasure of the governor:

(1) health care facilities;

(2) health care practitioners;

(3) health care workforce educators;

(4) telehealth technology experts;

(5) the telecommunications industry;

(6) the business community;

(7) health care insurance providers or other health care payers;

(8) the health information technology industry;

(9) Indian nations, tribes and pueblos;

(10) legislators;

(11) state agencies responsible for:

(a) telecommunications;

(b) public health;

(c) medicaid and social services;

(d) workforce development;

(e) children's health and social services;

(f) services for the elderly and persons with a disability;

(g) criminal justice;

(h) health policy and planning; and

(i) education; and

(12) other members as the governor may appoint to ensure appropriate cultural and geographic representation and the interests of the public.

C. The commission shall:

(1) identify how telehealth and health information technology can be used to increase access to care and implement state comprehensive health plans;

(2) identify barriers to telehealth and health information technology utilization and expansion, including payment, infrastructure, training and workforce availability;

(3) inventory the state's telehealth and health information technology assets, map available telecommunications infrastructure and examine the financial impact of failing to develop the state's telehealth and health information technology capacities;

(4) coordinate public and private sector initiatives to enhance networking, portal development and connectivity and to expand telehealth and health information technology and telecommunications capacity;

(5) establish subcommittees as the commission deems necessary to fulfill its purpose, powers and duties or to address specific telehealth and health information technology issues;

(6) identify specific actions to increase collaborative efforts and public-private partnerships to increase the use of telehealth and health information technology for

health care access development, patient outcome improvement, patient and workforce education and health care practitioner recruitment and development;

(7) develop and disseminate specific telehealth and health information technology guidelines to ensure quality of care, positive health outcomes, appropriate use of technology and protection of privacy and confidentiality;

(8) review and comment on initiatives, projects or grant applications to ensure telehealth and health information technology guidelines are met and maximum collaboration and cooperation across the state is encouraged;

(9) meet at least once each quarter at the call of the chair or vice chair, who shall be designated by the governor from among the membership; and

(10) report annually to the governor and the legislature on the state of the telehealth and health information technology system and the adequacy and allocation of telehealth and health information technology services throughout the state, providing the governor and the legislature with specific recommendations for improving telehealth and health information technology and related service systems.

D. A majority of the members of the commission constitutes a quorum for the transaction of business.

History: Laws 2005, ch. 55, § 4; 2007, ch. 14, § 4; 2007, ch. 46, § 13.

ARTICLE 1H
Bernalillo County Off-Reservation Native American Health Commission

24-1H-1. Short title.

This act [24-1H-1 to 24-1H-5 NMSA 1978] may be cited as the "Bernalillo County Off-Reservation Native American Health Commission Act".

History: Laws 2008, ch. 79, § 1.

24-1H-2. Definitions.

As used in the Bernalillo County Off-Reservation Native American Health Commission Act:

A. "commission" means the off-reservation Native American health commission;

B. "department" means the department of health;

C. "New Mexico tribe" means an Indian nation, tribe or pueblo located within New Mexico;

D. "off-reservation Native American" means a member of a federally recognized tribe or an Alaskan native who lives in an off-reservation urban area and is a resident;

E. "off-reservation nonprofit organization" means a corporate nonprofit entity that provides research, advocacy or health care services for the purpose of improving health care services or the overall health of Native Americans who are not living on reservations or pueblos;

F. "off-reservation urban area" means an area of land that is within Bernalillo county but not under the jurisdiction of a New Mexico tribe;

G. "resident" means a person who lives in and is domiciled in New Mexico; and

H. "secretary" means the secretary of health.

History: Laws 2008, ch. 79, § 2.

24-1H-3. Bernalillo county off-reservation Native American health commission created; membership.

A. The board of county commissioners of Bernalillo county may create the "Bernalillo county off-reservation Native American health commission" and appoint nine commission members for staggered three-year terms after soliciting nominations for its membership from appropriate off-reservation nonprofit organizations in Bernalillo county.

B. The board of county commissioners may agree to appoint the commission's members to include:

(1) someone who manages the Indian health service's Albuquerque-area urban Indian health program;

(2) someone experienced in the delivery of off-reservation Native American health care services in Bernalillo county;

(3) the tribal liaison for the department;

(4) two members who are members of a New Mexico tribe and have a background in providing or advocating for off-reservation Native American health care;

(5) three members who are members of a non-New Mexico tribe and have a background in providing or advocating for off-reservation Native American health care; and

(6) one member of the Bernalillo county community health council.

C. Upon approval by the board of county commissioners, the commission shall meet at least four times a year, elect its own chair for a term not to exceed three years and be paid as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

History: Laws 2008, ch. 79, § 3.

24-1H-4. Goals.

The goals of the commission may include:

A. within two years of being named, creation of an initial off-reservation Native American health care plan that includes:

(1) an estimate of the number and tribal affiliation of Native Americans living in the off-reservation urban area;

(2) an inventory of sources of non-emergency health care for off-reservation Native Americans, identifying federal, state and local public resources, tribal facilities and program duplications;

(3) a cross-jurisdictional budget analysis compiled from the most current annual figures reported by state and county facilities demonstrating the amount of health care funding for off-reservation Native Americans available to the existing non-emergency facilities;

(4) recommendations to eliminate duplications of services, improve access, initiate new services and consolidate non-emergency health care budgets for off-reservation Native Americans; and

(5) a comprehensive set of recommendations for redesigning the system of non-emergency health care available to off-reservation Native Americans;

B. within three years of being named, presentation of a plan for permanent restructuring of state and local budgets and services for off-reservation Native American health care to the legislature along with proposed legislation for that restructuring that addresses:

(1) financing for persons not eligible for medicaid;

(2) estimated costs or savings to the state from off-reservation Native Americans receiving medicaid;

(3) ways to enhance use of preventive care;

(4) nonresidential substance abuse treatment;

(5) residential treatment for substance abuse withdrawal;

(6) coordination of health care facilities with transportation services; and

(7) domestic violence and suicide prevention programs; and

C. a set of recommendations to the secretary on projects and programs that fall within the parameters of the initial off-reservation Native American health care plan and the permanent restructuring plans as funding becomes available.

History: Laws 2008, ch. 79, § 4.

24-1H-5. Off-reservation Native American health care plan implementation.

A. The secretary may contract for services as recommended by the commission, unless the secretary enters an objection with the commission, detailing reasons why recommended services are not in keeping with the initial off-reservation Native American health care plan or the permanent restructuring plan.

B. Nothing in the Bernalillo County Off-Reservation Native American Health Commission Act shall prohibit the department from contracting for categories of off-reservation Native American health care services prior to its effective date or for services it deems essential for public health.

History: Laws 2008, ch. 79, § 5.

ARTICLE 1I
Health Care Practitioner Agreements (Recompiled.)

24-1I-1. Recompiled.

History: Laws 2015, ch. 96, § 1; 2017, ch. 123, § 1; 2023, ch. 97, § 1; § 24-1I-1, recompiled as § 24A-4-1 by Laws 2024, ch. 39, § 132.

24-1I-2. Recompiled.

History: Laws 2015, ch. 96, § 2; 2017, ch. 123, § 2; § 24-1I-2, recompiled as § 24A-4-2 by Laws 2024, ch. 39, § 132.

24-1I-3. Recompiled.

History: Laws 2015, ch. 96, § 3; § 24-1I-3, recompiled as § 24A-4-3 by Laws 2024, ch. 39, § 132.

24-1I-4. Recompiled.

History: Laws 2015, ch. 96, § 4; § 24-1I-4, recompiled as § 24A-4-4 by Laws 2024, ch. 39, § 132.

24-1I-5. Recompiled.

History: Laws 2015, ch. 96, § 5; 2017, ch. 123, § 3; 2023, ch. 97, § 2; § 24-1I-5 , recompiled as § 24A-4-5 by Laws 2024, ch. 39, § 132.

ARTICLE 1J
County and Tribal Health Councils

24-1J-1. Short title.

This act [24-1J-1 to 24-1J-6 NMSA 1978] may be cited as the "County and Tribal Health Councils Act".

History: Laws 2019, ch. 57, § 1.

24-1J-2. Purpose of act.

The purpose of the County and Tribal Health Councils Act is to improve the health of New Mexicans by encouraging the development of comprehensive, community-based health planning councils to identify and address local health needs and priorities.

History: Laws 2019, ch. 57, § 2.

24-1J-3. Definitions.

As used in the County and Tribal Health Councils Act:

A. "board" means the board of county commissioners of a county or leadership of a tribe;

B. "department" means the department of health;

C. "health council" means a county or tribal health council;

D. "jurisdiction" means a county or a tribe; and

E. "tribe" means an Indian nation, tribe, pueblo or chapter located within the boundaries of the state.

History: Laws 2019, ch. 57, § 3.

24-1J-4. County and tribal health councils; designation.

A. Residents of a jurisdiction may create a county or tribal health council to carry out the provisions of the County and Tribal Health Councils Act; provided that:

(1) a board shall recognize only a single health council for its jurisdiction; and

(2) two or more boards may collaborate to recognize a common, single health council representing two or more jurisdictions.

B. A board shall recognize only a county or tribal health council whose members represent a diverse spectrum of community interests, including individuals and public, private and nonprofit entities.

C. Members of a health council shall elect from among themselves a chair for a term designated by the health council.

D. Health council members shall not be paid, but they may receive per diem and mileage expenses as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

History: Laws 2019, ch. 57, § 4.

24-1J-5. Health council functions.

A. A health council shall prepare a community health plan, updated at regular intervals. A health council shall report its community health plan to the board and to the department.

B. Each community health plan shall include:

(1) a county or tribal health assessment and inventory of health resources;

(2) identification of health priorities determined through independent, community-based planning processes; and

(3) strategies and resources to address health priorities.

C. A health council shall:

(1) monitor health and health care programs and services in order to identify potential gaps and to reduce potential duplication;

(2) collaborate with other entities to develop programs, networks, partnerships and coalitions as necessary to improve health;

(3) advise the board in its jurisdiction and other entities regarding policies that affect health;

(4) facilitate communication among local jurisdictions, state agencies and other entities; and

(5) identify additional public and private resources to improve health in its respective jurisdiction.

History: Laws 2019, ch. 57, § 5.

24-1J-6. Department; powers and duties.

The department shall:

A. in consultation with health councils, develop benchmarks, expectations and mechanisms to ensure the long-term viability of health councils;

B. in collaboration with universities, other state agencies and other public health entities, provide training, technical assistance and other supports to health councils;

C. in collaboration with other entities, develop a system to evaluate the effectiveness of health councils and the gathering of necessary evaluation data;

D. administer funding to support the work of the health councils, including local health council staffing, training and technical assistance, and monitor and evaluate contracts for funding; and

E. adopt and promulgate rules as necessary to carry out the purposes of the County and Tribal Health Councils Act and to strengthen community-based health planning and self-determination.

History: Laws 2019, ch. 57, § 6.

ARTICLE 1K
Primary Care Council (Repealed and Recompiled.)

24-1K-1. Repealed.

History: Laws 2021, ch. 87, § 1; § 24-1K-1, repealed by Laws 2024, ch. 39, § 133.

24-1K-2. Repealed.

History: Laws 2021, ch. 87, § 2; § 24-1K-2, repealed by Laws 2024, ch. 39, § 133.

24-1K-3. Recompiled.

History: Laws 2021, ch. 87, § 3; § 24-1K-3, recompiled and amended as § 24A-1-14 by Laws 2024, ch. 39, § 35.

ARTICLE 2
Crippled Children Services

24-2-1. Authority to conduct services for children with a disability.

The public health division of the department of health has authority to establish, administer and supervise activities to children who have a physical disability or whose condition may become a disability. The public health division also may supervise the administration of those services to children with a disability that are not administered directly by it.

History: 1978 Comp., § 24-2-1, enacted by Laws 1977, ch. 253, § 40; 2007, ch. 46, § 14.

ARTICLE 2A
Hemophilia Program

24-2A-1. Short title.

This act [24-2A-1 to 24-2A-3 NMSA 1978] may be cited as the "Theodore R. Montoya Memorial Hemophilia Program Act".

History: Laws 1980, ch. 26, § 1.

24-2A-2. Definitions.

As used in the Theodore R. Montoya Memorial Hemophilia Program Act:

A. "blood products" means certain components or factors obtained from whole blood which when periodically administered to persons suffering from hemophilia result in relief or control of the disease;

B. "eligible patient" means a person suffering from hemophilia whose case has been evaluated and accepted for provision of services by the hemophilia program established by the school;

C. "fund" means the hemophilia fund;

D. "hemophilia" means a genetic disease in which uncontrolled bleeding from otherwise minor causes may result in death or disability;

E. "hemophilia program" means the New Mexico comprehensive hemophilia diagnostic and treatment program established by the school to provide comprehensive clinical evaluation of patients suffering from hemophilia, out-patient blood product usage, counseling services to families of persons suffering from hemophilia and outreach to the public;

F. "provider" means any blood service or laboratory furnishing blood products to the school and its program administration for eligible patients;

G. "university" means the university of New Mexico; and

H. "secretary" means the secretary of health and environment [secretary of health].

History: Laws 1980, ch. 26, § 2.

24-2A-3. Hemophilia fund created; use; calculation of costs.

A. There is created in the state treasury the "hemophilia fund".

B. The fund shall be administered by the university and shall be used solely to provide hemophilia program services to eligible patients. The university may expend and distribute funds to:

(1) the university of New Mexico school of medicine for the costs of clinical evaluation, to include at least one visit per eligible patient per year;

(2) providers for the costs of blood products for each eligible patient, all as approved by the university of New Mexico school of medicine, to the extent not covered by insurance, medicaid or medicare;

(3) the university of New Mexico school of medicine for hemophilia program support, including nursing coordination, social services to patients and families and outreach for public education; and

(4) the university of New Mexico school of medicine for purchase of insurance or medicare coverage for patients who are eligible for coverage but have insufficient financial resources to pay the premiums.

History: Laws 1980, ch. 26, § 3; 2001, ch. 308, § 1.

ARTICLE 2B
Human Immunodeficiency Virus Tests

24-2B-1. Short title.

Chapter 24, Article 2B NMSA 1978 may be cited as the "Human Immunodeficiency Virus Test Act".

History: Laws 1989, ch. 227, § 1; 1993, ch. 107, § 1.

24-2B-2. Informed consent.

No person shall perform a test designed to identify the human immunodeficiency virus or its antigen or antibody without first obtaining the informed consent of the person upon whom the test is performed, except as provided in Section 24-2B-5, 24-2B-5.1, 24-2B-5.2 or 24-2B-5.3 NMSA 1978. Informed consent shall be preceded by an explanation of the test, including its purpose, potential uses and limitations and the meaning of its results. Consent need not be in writing if there is documentation in the medical record that the test has been explained and the consent has been obtained. The requirement for full pre-test counseling may be waived under the following circumstances:

A. the performance of a prenatal test to determine if the human immunodeficiency virus or its antigen is present in a pregnant woman; provided that the woman, or her authorized representative, after having been informed of the option to decline the human immunodeficiency virus test, may choose not to have the human immunodeficiency virus test performed as a part of the routine prenatal testing if she or her authorized representative provides a written statement as follows:

"I am aware that a test to identify the human immunodeficiency virus or its antigen or antibody is a part of routine prenatal testing. However, I voluntarily and knowingly choose not to have the human immunodeficiency virus test performed.

_____
(Name of patient or authorized representative)

_____
(Signature and date)."; or

B. when human immunodeficiency virus testing is part of routine medical care.

History: Laws 1989, ch. 227, § 2; 1993, ch. 107, § 2; 1996, ch. 80, § 7; 2000, ch. 36, § 1; 2007, ch. 108, § 1.

24-2B-3. Substituted consent.

Informed consent shall be obtained from a legal guardian or other person authorized by law when the person is not competent. A minor shall have the capacity to give informed consent to have the human immunodeficiency virus test performed on himself.

History: Laws 1989, ch. 227, § 3.

24-2B-4. Mandatory counseling.

No positive test result shall be revealed to the person upon whom the test was performed without providing or referring that person for individual counseling about:

A. the meaning of the test results;

B. the possible need for additional testing;

C. the availability of appropriate health care services, including mental health care, social and support services; and

D. the benefits of locating and counseling any individual by whom the infected person may have been exposed to the human immunodeficiency virus and any individual whom the infected person may have exposed to the human immunodeficiency virus.

History: Laws 1989, ch. 227, § 4; 2013, ch. 72, § 1.

24-2B-5. Informed consent not required.

Informed consent for testing is not required and the provisions of Section 24-2B-2 NMSA 1978 do not apply for:

A. a health care provider or health facility performing a test on the donor or recipient when the health care provider or health facility procures, processes, distributes or uses a human body part, including tissue and blood or blood products, donated for a purpose specified under the Uniform Anatomical Gift Act [repealed] or for transplant recipients or semen provided for the purpose of artificial insemination and the test is necessary to ensure medical acceptability of a recipient or the gift or semen for the purposes intended;

B. the performance of a test in bona fide medical emergencies when the subject of the test is unable to grant or withhold consent and the test results are necessary for medical diagnostic purposes to provide appropriate emergency care or treatment, except that post-test counseling or referral for counseling shall nonetheless be required when the individual is able to receive that post-test counseling. Necessary treatment shall not be withheld pending test results;

C. the performance of a test for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher; or

D. the performance of a test done in a setting where the identity of the test subject is not known, such as in public health testing programs and sexually transmitted disease clinics.

History: Laws 1989, ch. 227, § 5; 2000, ch. 36, § 2; 2003, ch. 342, § 1; 2007, ch. 108, § 2.

24-2B-5.1. Informed consent not required; testing of persons convicted of certain criminal offenses; responsibility to administer and pay for test.

A. A test designed to identify the human immunodeficiency virus or its antigen or antibody may be performed, without the offender's consent, on an offender convicted pursuant to state law of any criminal offense:

(1) involving contact between the penis and vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva;

(5) involving contact between the mouth and anus; or

(6) when the court determines from the facts of the case that there was a transmission or likelihood of transmission of blood, semen or vaginal secretions from the offender to the victim.

B. If consent to perform a test on an offender cannot be obtained pursuant to the provisions of Section 24-2B-2 or 24-2B-3 NMSA 1978, the district attorney or other prosecutorial authority shall, upon the request of the victim of a criminal offense described in Subsection A of this section, petition the court to order that a test be performed on the offender not later than forty-eight hours from the date of the court order. If the victim of the criminal offense is a minor or incompetent, the parent or legal guardian of the victim may request the district attorney or other prosecutorial authority to petition the court to order that a test be performed on the offender. The petition and all proceedings in connection with the petition shall be under seal. The results of the test shall be disclosed as soon as practicable and only to the offender and to the victim or the victim's parent or legal guardian. If the offender has a positive test result, both the offender and victim shall be provided with counseling, as described in Section 24-2B-4 NMSA 1978.

C. If the offender is sentenced to imprisonment in a state corrections facility, the court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

D. If the offender is convicted of a misdemeanor or petty misdemeanor offense or is convicted of a felony offense that is suspended or deferred, the court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

E. If the offender is a minor adjudicated as a delinquent child pursuant to the provisions of the Children's Code [Chapter 32A NMSA 1978] and the court transfers legal custody of the minor to the children, youth and families department, the court's order shall direct the children, youth and families department to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

F. If the offender is a minor adjudicated as a delinquent child pursuant to the provisions of the Children's Code and the court does not transfer legal custody of the minor to the children, youth and families department, the court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

History: 1978 Comp., § 24-2B-5.1, enacted by Laws 1993, ch. 107, § 3; 2010, ch. 26, § 1.

24-2B-5.2. Informed consent not required; testing of persons formally charged for allegedly committing certain criminal offenses; responsibility to administer and pay for test.

A. A test designed to identify the human immunodeficiency virus or its antigen or antibody may be performed, without the person's consent, on a person upon the filing of a complaint, information or an indictment alleging that the person committed a state criminal offense:

(1) involving contact between the penis and vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva; or

(5) involving contact between the mouth and anus.

B. If consent to perform a test on an alleged offender cannot be obtained pursuant to the provisions of Section 24-2B-2 or 24-2B-3 NMSA 1978, the district attorney or other prosecutorial authority shall, upon the request of the victim of the alleged criminal

offense described in Subsection A of this section, petition the court to order that a test be performed on the alleged offender not later than forty-eight hours from the date of the court order; provided that the same test is first performed on the victim of the alleged criminal offense. If the victim of the alleged criminal offense is a minor or incompetent, the parent or legal guardian of the victim of the alleged criminal offense may request the district attorney or other prosecutorial authority to petition the court to order that a test be performed on the alleged offender. The test may be performed on the alleged offender regardless of the result of the test performed on the victim of the alleged offense.

C. The court may issue an order based on a finding of good cause after a hearing at which both the victim of the alleged criminal offense and the alleged offender have the right to be present. During the hearing, only affidavits, counter affidavits and medical reports regarding the facts that support or rebut the issuance of an order shall be admissible. The hearing shall be conducted within seventy-two hours after the district attorney or other prosecutorial authority petitions the court for the order. The petition and all proceedings in connection therewith shall be under seal.

D. The results of the test shall be disclosed as soon as practicable and only to the alleged offender and to the victim of the alleged criminal offense or the victim's parent or legal guardian. When the victim of the alleged criminal offense or the alleged offender has a positive test result, both the alleged offender and the victim of the alleged criminal offense shall be provided with counseling, as described in Section 24-2B-4 NMSA 1978.

E. The court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

F. A prosecuting attorney may not use in a criminal proceeding arising out of the alleged criminal offense the fact that a test was administered to the alleged offender or the results of the test.

G. The provisions of this section shall not affect the rights and remedies available to the victim of the alleged criminal offense and alleged offender in any civil action.

H. The administration of a test to an alleged offender pursuant to the provisions of this section shall not preclude the subsequent administration of follow-up tests pursuant to the provisions of Section 24-2B-5.1 NMSA 1978.

History: 1978 Comp., § 24-2B-5.2, enacted by Laws 1996, ch. 80, § 8; 2010, ch. 26, § 2.

24-2B-5.3. Informed consent not required; testing of persons who are source individuals.

A. As used in this section:

(1) "exposed individual" means a health care provider, first responder or other person, including an employee, volunteer or independent contracted agent of a health care provider or law enforcement agency, while acting within the scope of his employment; or a person who, while receiving services from a health care provider, is significantly exposed to the blood or other potentially infectious material of another person, when the exposure is proximately the result of the activity of the exposed individual or receipt of health care services from the source individual;

(2) "significantly exposed" means direct contact with blood or other potentially infectious material of a source individual in a manner that is capable of transmitting the human immunodeficiency virus; and

(3) "source individual" means a person whose blood or other potentially infectious material may have been or has been the source of a significant exposure.

B. A test designed to identify the human immunodeficiency virus or its antigen or antibody may be performed without the consent of a source individual when an exposed individual is significantly exposed.

C. If consent to perform a test on a source individual cannot be obtained pursuant to the provisions of Section 24-2B-2 or 24-2B-3 NMSA 1978, the exposed individual may petition the court to order that a test be performed on the source individual; provided that the same test shall first be performed on the exposed individual. The test may be performed on the source individual regardless of the result of the test performed on the exposed individual. If the exposed individual is a minor or incompetent, the parent or guardian may petition the court to order that a test be performed on the source individual.

D. The court may issue an order based on a finding of good cause after a hearing at which both the source individual and the exposed individual have the right to be present. The hearing shall be conducted within seventy-two hours after the petition is filed. The petition and all proceedings in connection with the petition shall be under seal. The test shall be administered on the source individual within three days after the order for testing is entered.

E. The results of the test shall be disclosed only to the source individual and the exposed or the exposed individual's parent or guardian. When the source individual or the exposed individual has a positive test result, both shall be provided with counseling as provided in Section 24-2B-4 NMSA 1978.

History: 1978 Comp., § 24-2B-5.3, enacted by Laws 2000, ch. 36, § 3.

24-2B-6. Confidentiality.

A. No person or the person's agents or employees who require or administer the test shall disclose the identity of any person upon whom a test is performed or the result

of such a test in a manner that permits identification of the subject of the test, except to the following persons:

(1) the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

(2) any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

(3) an authorized agent, a credentialed or privileged physician or employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

(4) the department of health in accordance with reporting requirements established by regulation;

(5) the department of health for the purpose of providing partner services;

(6) a health facility or health care provider that procures, processes, distributes or uses:

(a) a human body part from a deceased person, with respect to medical information regarding that person;

(b) semen provided prior to the effective date of the Human Immunodeficiency Virus Test Act for the purpose of artificial insemination;

(c) blood or blood products for transfusion or injection; or

(d) human body parts for transplant with respect to medical information regarding the donor or recipient;

(7) health facility staff committees or accreditation or oversight review organizations that are conducting program monitoring, program evaluation or service reviews, so long as any identity remains confidential;

(8) authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

(9) for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

B. The department of health may disclose human immunodeficiency virus test results, including the identity of any person upon whom a test is performed:

(1) to the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

(2) to the person who ordered the test or that person's agents or employees;

(3) in the conduct of public health practice, to appropriate municipal, county, state, federal or tribal public health agencies having at least equivalent security and confidentiality standards for human immunodeficiency virus test results as maintained by the department of health; and

(4) to health care personnel where necessary to protect the health of the individual who is the subject of the test or an individual who was significantly exposed to the subject of the test, provided that the health care personnel first provide to the department of health for review relevant medical records or other written attestations that document the need for access to the person's confidential human immunodeficiency virus test results.

C. For the purposes of this section:

(1) "partner services" means a protocol that the department of health establishes by regulation similar to those protocols and regulations for other reportable sexually transmitted diseases for contacting individuals whom it identifies to be at risk of human immunodeficiency virus infection due to contact with an individual whom it has identified, through reporting made pursuant to Paragraph (4) or (5) of Subsection A of this section, as having been infected with human immunodeficiency virus;

(2) "test" means a procedure that definitively diagnoses the presence of human immunodeficiency virus infection, either through the detection of the virus itself or the detection of antibodies against the virus; and

(3) "public health practice" means a population-based activity or individual effort aimed primarily at the prevention of injury, disease or premature mortality or the promotion of health in a community, including:

(a) surveillance and response; and

(b) developing public health policy.

History: Laws 1989, ch. 227, § 6; 1997, ch. 214, § 1; 2010, ch. 4, § 1; 2013, ch. 72, § 2.

24-2B-7. Disclosure statement.

No person to whom the results of a test have been disclosed may disclose the test results to another person except as authorized by the Human Immunodeficiency Virus Test Act. Whenever disclosure is made pursuant to that act, it shall be accompanied by a statement in writing that includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both."

History: Laws 1989, ch. 227, § 7; 1996, ch. 80, § 9.

24-2B-8. Disclosure.

Nothing in the Human Immunodeficiency Virus Test Act shall be construed to prevent a person who has been tested from disclosing in any way to any other person his own test results. Any victim of an alleged criminal offense who receives information pursuant to Section 24-2B-5.2 NMSA 1978 may disclose the test results as is reasonably necessary to protect his health and safety or the health and safety of his family or sexual partner.

History: Laws 1989, ch. 227, § 8; 1996, ch. 80, § 10.

24-2B-9. Penalty.

A person who makes an unauthorized disclosure of the results of a test designed to identify the human immunodeficiency virus or its antigen or antibody is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both.

History: 1978 Comp., § 24-2B-9, enacted by Laws 1996, ch. 80, § 11.

ARTICLE 2C
Harm Reduction

24-2C-1. Short title.

Sections 1 through 6 [24-2C-1 to 24-2C-6 NMSA 1978] of this act may be cited as the "Harm Reduction Act".

History: Laws 1997, ch. 256, § 1.

24-2C-2. Repealed.

History: Laws 1997, ch. 256, § 2; repealed by Laws 2022, ch. 4, § 5.

24-2C-3. Definitions.

As used in the Harm Reduction Act:

A. "department" means the department of health; and

B. "participant" means a person who receives supplies or devices or services provided by the harm reduction program.

History: Laws 1997, ch. 256, § 3; 2022, ch. 4, § 1.

24-2C-4. Harm reduction program created; department responsibilities.

A. The department shall:

(1) establish and administer a program that shall be known as the "harm reduction program" to reduce overdose mortality and other negative health outcomes associated with drug use;

(2) pursuant to rules established by the department, qualify persons as harm reduction program participants, issue a document that identifies the bearer of the document as a participant and provide the bearer of the document with access to supplies, devices or services provided by the program;

(3) compile data to assist in planning and evaluating efforts to combat overdose mortality and other negative health outcomes associated with drug use; and

(4) make an annual report, including legislative recommendations, to the legislative health and human services committee by October 1 each year.

B. The department shall appoint an advisory committee to include representation from:

(1) the office of the attorney general;

(2) the New Mexico state police division of the department of public safety;

(3) the infectious disease prevention and control bureau of the department;

(4) the director of the epidemiology and response division of the department or the director's designee;

(5) a medical officer of the public health division of the department; and

(6) other persons or representatives as chosen by the secretary of health to ensure a thorough and unbiased evaluation of the program established under the Harm Reduction Act.

C. The advisory committee shall:

(1) develop policies and procedures for evaluation of the harm reduction program;

(2) develop criteria for data collection and program evaluation; and

(3) meet as necessary to monitor and analyze data and produce a report on the harm reduction program's impact on overdose mortality and other negative health outcomes associated with drug use.

D. The department may contract with private providers to operate the harm reduction program.

E. The department shall promulgate rules as necessary for the administration of the Harm Reduction Act, including developing criteria for the types of supplies or devices provided pursuant to the harm reduction program and standards for distribution of those supplies or devices through that program. The criteria and standards shall be developed to provide supplies and devices in order to reduce:

(1) cases of negative health outcomes associated with drug use, such as overdoses or the spread of infectious disease; and

(2) harm by promoting reduced use of non-sterile items and improving participant engagement in harm reduction services and prevention education.

History: Laws 1997, ch. 256, § 4; 2022, ch. 4, § 2.

24-2C-5. Program.

The harm reduction program shall provide participants with:

A. sterile hypodermic syringes and needles in exchange for used hypodermic syringes, needles or other objects used to inject controlled substances or controlled substance analogs into the human body;

B. other objects used to prepare or consume controlled substances or controlled substance analogs;

C. supplies or devices used for testing controlled substances or controlled substance analogs for potentially dangerous adulterants;

D. supplies or devices approved by the department for distribution in accordance with rules established pursuant to Subsection E of Section 24-2C-4 NMSA 1978;

E. education on the prevention of:

(1) the transmission of the human immunodeficiency virus and hepatitis B and C; and

(2) drug overdose mortality and other negative health outcomes; and

F. referral to substance abuse treatment services.

History: Laws 1997, ch. 256, § 5; 2022, ch. 4, § 3.

24-2C-6. Repealed.

History: Laws 1997, ch. 256, § 6; repealed by Laws 2022, ch. 4, § 5.

ARTICLE 2D
Pain Relief

24-2D-1. Short title.

Chapter 24, Article 2D NMSA 1978 may be cited as the "Pain Relief Act".

History: Laws 1999, ch. 126, § 1; 2019, ch. 94, § 1.

24-2D-2. Definitions.

As used in the Pain Relief Act:

A. "accepted guideline" means the most current clinical pain management guideline developed by the American geriatrics society or the American pain society or a clinical pain management guideline based on evidence and expert opinion that has been accepted by the New Mexico medical board;

B. "acute pain" means the normal, predicted physiological response to a noxious chemical or thermal or mechanical stimulus, typically associated with invasive procedures, trauma or disease and generally time-limited;

C. "board" means the licensing board of a health care provider;

D. "chronic pain" means pain that persists after reasonable medical efforts have been made to relieve the pain or its cause and that continues, either continuously or episodically, for longer than three consecutive months. "Chronic pain" does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition;

E. "clinical expert" means a person who by reason of specialized education or substantial relevant experience in pain management has knowledge regarding current standards, practices and guidelines;

F. "disciplinary action" means any formal action taken by a board against a health care provider, upon a finding of probable cause that the health care provider has engaged in conduct that violates the board's practice act;

G. "health care provider" means a person who is licensed or otherwise authorized by law to provide health care in the ordinary course of business or practice of the person's profession and who has prescriptive authority within the limits of the person's license;

H. "opioid analgesic" means buprenorphine, butorphanol, codeine, hydrocodone, hydromorphine, levorphanol, meperidine, methadone, morphine, nalbuphine, oxycodone, oxymorphone, pentazocine and propoxyphene as well as their brand names, isomers and combinations;

I. "opioid antagonist" means a drug approved by the federal food and drug administration that when administered negates or neutralizes in whole or in part the pharmacological effects of an opioid analgesic in the body, including naloxone and such other medications approved by the board of pharmacy for the reversal of opioid analgesic overdoses;

J. "pain" means acute and chronic pain; and

K. "therapeutic purpose" means the use of pharmaceutical and non-pharmaceutical medical treatment that conforms substantially to accepted guidelines for pain management.

History: Laws 1999, ch. 126, § 2; 2005, ch. 140, § 1; 2012, ch. 41, § 1; 2019, ch. 94, § 2.

24-2D-3. Disciplinary action; evidentiary requirements.

A. A health care provider who prescribes, dispenses or administers medical treatment for the purpose of relieving pain and who can demonstrate by reference to an

accepted guideline that the provider's practice substantially complies with that guideline and with the standards of practice identified in Section 24-2D-4 NMSA 1978 shall not be disciplined pursuant to board action or criminal prosecution, unless the showing of substantial compliance with an accepted guideline by the health care provider is rebutted by clinical expert testimony. If no currently accepted guidelines are available, then rules issued by the board may serve the function of such guidelines for purposes of the Pain Relief Act. The board rules shall conform to the intent of that act. Guidelines established primarily for purposes of coverage, payment or reimbursement do not qualify as an "accepted guideline" when offered to limit treatment options otherwise covered within the Pain Relief Act.

B. In the event that a disciplinary action or criminal prosecution is pursued, the board or prosecutor shall produce clinical expert testimony supporting the finding or charge of violation of disciplinary standards or other legal requirements on the part of the health care provider. A showing of substantial compliance with an accepted guideline shall only be rebutted by clinical expert testimony.

C. The provisions of this section apply to health care providers in the treatment of pain, regardless of a patient's prior or current chemical dependency or addiction. Each board shall adopt rules establishing standards and procedures for the application of the Pain Relief Act, including pain management for patients with substance use disorders.

D. In an action brought by a board against a health care provider based on treatment of a patient for pain, the board shall consider the totality of the circumstances and shall not use as the sole basis of the action:

(1) a patient's age;

(2) a patient's diagnosis;

(3) a patient's prognosis;

(4) a patient's history of drug abuse;

(5) the absence of consultation with a pain specialist; or

(6) the quantity of medication prescribed or dispensed.

History: Laws 1999, ch. 126, § 3; 2005, ch. 140, § 2; 2012, ch. 41, § 2.

24-2D-4. Disciplinary action; prohibitions.

Nothing in the Pain Relief Act shall prohibit discipline or prosecution of a health care provider for:

A. failing to maintain complete, accurate and current records documenting the physical examination and medical history of the patient, the basis for the clinical diagnosis of the patient and the treatment plan for the patient;

B. writing false or fictitious prescriptions for controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 or Sections 26-1-23 and 30-31-18 NMSA 1978;

C. prescribing, administering or dispensing pharmaceuticals in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 or Sections 26-1-23 and 30-31-18 NMSA 1978; or

D. diverting medications prescribed for a patient to the provider's personal use or to other persons.

History: Laws 1999, ch. 126, § 4.

24-2D-5. Notification.

The board shall notify the following persons of the Pain Relief Act and accepted guidelines:

A. health care providers under its jurisdiction; and

B. a health care provider being investigated by the board in relation to the provider's pain management practices.

History: Laws 1999, ch. 126, § 5; 2012, ch. 41, § 3.

24-2D-5.1. Pain management continuing education.

A board shall require non-cancer pain management continuing education as determined by its rules for health care providers under the board's jurisdiction who hold a federal drug enforcement administration registration and licensure to prescribe opioids.

History: Laws 2005, ch. 140, § 4; 2012, ch. 41, § 4.

24-2D-5.2. Overdose prevention and pain management advisory council created; duties.

A. The "overdose prevention and pain management advisory council" is created and shall be administratively attached to the department of health. Members of the council shall be appointed by the governor to consist of one representative each from the department of health, the human services department [health care authority

department], the department of public safety, the New Mexico medical board, the board of nursing, the board of pharmacy, the board of acupuncture and oriental medicine, the New Mexico board of dental health care, the chiropractic board, the university of New Mexico health sciences center, a harm reduction organization, a third-party payer, a statewide medical association, a statewide association of pharmacists, a statewide association of nurse practitioners, a statewide association of certified registered nurse anesthetists and a statewide association of osteopathic physicians; one person who is a pain management specialist; one person who is an addiction specialist; one person who is a consumer health care advocate; and one person who has no direct ties or pecuniary interest in the health care field.

B. The council shall meet at least quarterly to review the current status of overdose prevention and current pain management practices in New Mexico and national overdose prevention and pain management standards and educational efforts for both consumers and professionals. The council shall also make recommendations regarding overdose prevention and pain management practices. The council may create subcommittees as needed. Members who are not public employees shall receive per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978]. Public employee members shall receive mileage from their respective employers for attendance at council meetings.

History: Laws 2005, ch. 140, § 3; 2012, ch. 41, § 5; 2018, ch. 12, § 1; 2021, ch. 54, § 8.

24-2D-6. Scope of act.

Nothing in the Pain Relief Act shall be construed as expanding the authorized scope of practice of health care providers.

History: Laws 1999, ch. 126, § 6.

24-2D-7. Requirements for health care providers who prescribe, distribute or dispense opioid analgesics.

A. A health care provider who prescribes, distributes or dispenses an opioid analgesic for the first time to a patient shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist. With respect to a patient to whom an opioid analgesic has previously been prescribed, distributed or dispensed by the health care provider, the health care provider shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist on the first occasion that the health care provider prescribes, distributes or dispenses an opioid analgesic each calendar year.

B. A health care provider who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply. The prescription for the opioid antagonist shall be accompanied by written information regarding the temporary effects of the opioid antagonist and

techniques for administering the opioid antagonist. That written information shall contain a warning that a person administering the opioid antagonist should call 911 immediately after administering the opioid antagonist, unless that person is a health care provider as provided in the Pain Relief Act.

History: Laws 2019, ch. 94, § 3; 2023, ch. 102, § 1.

ARTICLE 2E
Testing for Viral Hepatitis (Repealed.)

24-2E-1. Repealed.

History: Laws 2001, ch. 136, § 1; repealed by Laws 2013, ch. 28, § 1.

24-2E-2. Repealed.

History: Laws 2001, ch. 136, § 2; repealed by Laws 2013, ch. 28, § 2.

24-2E-3. Repealed.

History: Laws 2001, ch. 136, § 3; repealed by Laws 2013, ch. 28, § 1.

ARTICLE 3
Sickle Cell Trait and Sickle Cell Anemia

24-3-1. Sickle cell trait and sickle cell anemia; education; diagnosis.

A. The health services division [public health division] of the health and environment department [department of health] shall provide by regulation procedures to establish, maintain, promote and effectuate a program designed to educate the general public and public and private school students regarding the nature and inheritance of sickle cell trait and sickle cell anemia. The division shall consult and advise the state board of education [public education department] concerning development and use of informational and educational materials relating to sickle cell trait and sickle cell anemia.

B. The health services division [public health division] of the health and environment department [department of health] shall provide by regulation for diagnosis of sickle cell trait and sickle cell anemia. Regulations shall provide for, among other things:

(1) the making available to all physicians by the health services division [public health division] of current information concerning the nature, effects, diagnosis and treatment of sickle cell trait and sickle cell anemia;

(2) the testing of all school-age children who may be susceptible to sickle cell trait and sickle cell anemia, at least once, as a part of the school health program; and

(3) the making available without cost to any person unable to afford the services of a physician, tests to diagnose sickle cell trait and sickle cell anemia.

History: 1953 Comp., § 12-3-45, enacted by Laws 1973, ch. 300, § 1; 1977, ch. 253, § 25.

ARTICLE 3A
Certificates of Need for New Health Services (Repealed.)

24-3A-1 to 24-3A-13. Repealed.

ARTICLE 3B
Department of Health Education

24-3B-1. Short title.

Chapter 24, Article 3B NMSA 1978 may be cited as the "Department of Health Education Act".

History: 1978 Comp., § 24-3B-1, enacted by Laws 1978, ch. 211, § 1; 1991, ch. 25, § 27.

24-3B-2. Definitions.

As used in the Department of Health Education Act:

A. "department" means the department of health;

B. "educational appraisal and review committee" means the educational appraisal and review committee as defined in the special education regulations of the state board of education [public education department];

C. "evaluated school-age resident" means a school-age resident who has been evaluated by the department according to the state board of education [public education department] special education regulations;

D. "fund" means the department of health education fund;

E. "institution-bound resident" means an evaluated school-age resident who is not enrolled in a public school;

F. "referred school-age resident" means an evaluated school-age resident who has been referred to a school district for enrollment;

G. "school-age resident" means a school-age person as defined in Section 22-1-2 NMSA 1978 who is a client as defined in Section 43-1-3 NMSA 1978 in a state institution under the authority of the secretary; and

H. "secretary" means the secretary of health.

History: 1978 Comp., § 24-3B-2, enacted by Laws 1978, ch. 211, § 2; 1991, ch. 25, § 28.

24-3B-3. Education of school age residents.

A. All school age residents shall be evaluated by the department for purposes of educational placement according to the special education regulations of the state board of education [public education department].

B. Any evaluated school age resident not recommended for placement in a public school by the department or as a result of the appeal process shall be provided an educational program by the institution in which he is a school age resident. All such educational programs shall be in accordance with the special education regulations of the state board of education [public education department].

C. The department shall refer any evaluated school age resident who has been recommended for placement in a public school to a school district for enrollment.

D. The educational appraisal and review committee of a school district shall evaluate and recommend placement of all referred school age residents according to the placement process as provided in the special education regulations of the state board of education [public education department]. A school district shall enroll all referred school age residents who have been recommended for placement in a public school by the educational appraisal and review committee of the school district.

E. The department may appeal any recommendation to not place a referred school age resident in a public school only if such recommendation is made by the educational appraisal and review committee of the school district where the institution, in which the referred school age resident is a client, is located. The appeal process shall be as provided in the special education regulations of the state board of education [public education department]. Any referred school age resident who has been recommended for placement in a public school as a result of the appeal process shall be enrolled in the school district where the institution, in which the referred school age resident is a

client, is located, as provided in Paragraph (2), Subsection C of Section 22-12-4 NMSA 1978 [repealed].

F. All school age residents who are enrolled in a public school shall be counted in the special education membership of the school district.

G. Transportation for all school age residents enrolled in a public school shall be provided to and from the institution in which they are clients and the public school in which they are enrolled. Such transportation shall be provided in accordance with Section 22-8-2 and Sections 22-16-1 through 22-16-10 NMSA 1978.

History: 1978 Comp., § 24-3B-2 enacted by Laws 1978, ch. 211, § 3.

24-3B-4. Fund created; use; calculation.

A. There is created the "health and environment department education fund" in the state treasury.

B. The fund shall be used solely to provide educational services to institution-bound residents of the state institutions under the authority of the secretary.

C. The secretary shall distribute the fund to institutions under his authority within limits established by law.

D. The secretary shall determine the allocation to each institution from the fund according to the annual program cost of that institution as calculated on September 15 of the fiscal year.

E. The annual program cost for each institution shall be determined by the following calculation:

number of institution-bound residents	x 3.9 x	dollar value per program unit	=	annual program cost

F. The dollar value per program unit shall be the same as the dollar value per program unit as established by the legislature for the state equalization guarantee.

G. Each director of each state institution under the authority of the secretary shall submit annually, on or before October 15, to the secretary an estimate for the succeeding fiscal year of the number of institution-bound residents and any other information necessary to calculate annual program cost.

H. The secretary shall submit annually, on or before November 15, to the department of finance and administration the recommendations of the department

regarding the fund for the succeeding fiscal year, for inclusion in the executive budget document.

History: 1978 Comp., § 24-3B-4, enacted by Laws 1978, ch. 211, § 4.

ARTICLE 4
District Health Officers

24-4-1. District health officer; compensation; private practice prohibited; exception.

Each district health officer shall receive the salary prescribed for such position by the state personnel board. The salary shall constitute full authority for the district health officers and they shall receive no other salary payment or fees from any other public source. No district health officer shall engage in the private practice of medicine, maintain an office for the practice of medicine, nor accept nor receive any fee, gratuity or emolument of any form for rendering medical or surgical service to any citizen of this state, except that permission for such practice may be given by the secretary of the health and environment department [secretary of health] in any district, the board of which has declared an emergency to exist.

History: Laws 1935, ch. 131, § 6; 1941 Comp., § 71-206; Laws 1947, ch. 172, § 4; 1953 Comp., § 12-2-6; Laws 1957, ch. 174, § 3; 1973, ch. 4, § 8; 1977, ch. 253, § 17; 1980, ch. 81, § 1.

24-4-2. Local public health offices; regional director; health officer; expenses.

A. The board of county commissioners of each county shall provide suitable quarters for:

(1) the local public health offices, including office space for the administrative staff, office space for health care personnel and clinic space and waiting space for patients, their friends and families; and

(2) the regional director and regional health officer, including office space for the administrative staff.

B. The boards of county commissioners shall make proper provision for all office and other expense, including utilities and maintenance but excluding janitorial services, incurred in enforcing the health laws and regulations within the counties in which the expense is incurred.

C. The board of county commissioners of each county may, upon adoption of a resolution approved by the department of finance and administration, deposit such county funds as are provided in this section with the state treasurer to the credit of the department of health for such purposes as are provided in this section at such times as such funds are available; provided the depositing of such funds with the state treasurer is upon a voucher approved by the board of county commissioners subject to all statutes and regulations covering the disbursement of county funds, excepting that such funds may be so deposited prior to said payments being due and payable; and provided further that no such deposits shall be in excess of any line item of the approved county health budget.

History: Laws 1935, ch. 131, § 7; 1941 Comp., § 71-207; 1953 Comp., § 12-2-7; Laws 1957, ch. 174, § 4; 1977, ch. 24, § 134; 1977, ch. 253, § 18; 1980, ch. 81, § 2; 2017, ch. 87, § 21.

24-4-3. Additional health officers; offices; expenses.

A. Whenever, in the opinion of the director of the public health division of the department of health, conditions require the employment of persons in addition to the district health officer to properly execute the health laws and regulations in any county, the board of county commissioners of such county, with the approval of the secretary of health, shall provide suitable quarters for such additional persons. The boards of county commissioners shall make proper provision for all office expenses and other expenses, including utilities and maintenance, for such additional persons.

B. The board of county commissioners of such county may, upon adoption of a resolution approved by the secretary of finance and administration, deposit county funds for such purposes as are provided pursuant to this section with the state treasurer to the credit of the department of health for such purposes as are provided in this section at such time as such funds are available. The depositing of such funds with the state treasurer shall be upon a voucher approved by the board of county commissioners subject to all statutes and regulations covering the disbursement of county funds except that such funds may be so deposited prior to disbursement being due and payable. No such deposits shall be in excess of the approved budget for this purpose.

History: Laws 1919, ch. 85, § 36, added by 1920 (S.S.), ch. 2, § 1 (36); 1921, ch. 143, § 1 (36); 1929, ch. 55, § 1 (36); C.S. 1929, § 110-331; Laws 1941, ch. 97, § 1; 1941 Comp., § 71-211; 1953 Comp., § 12-2-11; Laws 1957, ch. 174, § 5; 1973, ch. 4, § 9; 1977, ch. 247, § 135; 1977, ch. 253, § 19; 1983, ch. 301, § 71; 2017, ch. 87, § 22.

ARTICLE 5
Immunization

24-5-1. Immunization regulations.

The public health division of the department of health shall, after consultation with the state board of education [public education department], promulgate rules and regulations governing the immunization against diseases deemed to be dangerous to the public health, to be required of children attending public, private, home or parochial schools in the state. The immunizations required and the manner and frequency of their administration shall conform to recommendations of the advisory committee on immunization practices of the United States department of health and human services and the American academy of pediatrics. The public health division shall supervise and secure the enforcement of the required immunization program.

History: 1953 Comp., § 12-3-4.1, enacted by Laws 1959, ch. 329, § 1; 1977, ch. 253, § 20; 1985, ch. 21, § 5; 1998, ch. 26, § 1.

24-5-1.1. Short title.

Chapter 24, Article 5 NMSA 1978 may be cited as the "Immunization Act".

History: Laws 2004, ch. 45, § 1.

24-5-2. Unlawful to enroll in school unimmunized; unlawful to refuse to permit immunization.

It is unlawful for any student to enroll in school unless he has been immunized, as required under the rules and regulations of the health services division [public health division] of the health and environment department [department of health], and can provide satisfactory evidence of such immunization. Provided that, if he produces satisfactory evidence of having begun the process of immunization, he may enroll and attend school as long as the immunization process is being accomplished in the prescribed manner. It is unlawful for any parent to refuse or neglect to have his child immunized, as required by this section, unless the child is properly exempted.

History: 1953 Comp., § 12-3-4.2, enacted by Laws 1959, ch. 329, § 2; 1975, ch. 25, § 1; 1977, ch. 253, § 21.

24-5-3. Exemption from immunization.

A. Any minor child through the child's parent or guardian may file with the health authority charged with the duty of enforcing the immunization laws:

(1) a certificate of a licensed physician, a physician assistant or a certified nurse practitioner stating that the physical condition of the child is such that immunization would seriously endanger the life or health of the child;

(2) an affidavit or written affirmation from an officer of a recognized religious denomination that the child's parents or guardians are bona fide members of a

denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing; or

(3) an affidavit or written affirmation from the child's parent or legal guardian that the parent's or legal guardian's religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agent.

B. Upon filing and approval of such certificate, affidavit or affirmation, the child is exempt from the legal requirement of immunization for a period not to exceed nine months on the basis of any one certificate, affidavit or affirmation.

History: 1953 Comp., § 12-3-4.3, enacted by Laws 1959, ch. 329, § 3; 1979, ch. 42, § 1; 2023, ch. 94, § 1.

24-5-4. Superintendent; duty to report.

It is the duty of each school superintendent, whether of a public, private or parochial school, to cause to be prepared a record showing the required immunization status of every child enrolled in or attending a school under his jurisdiction. These records must be kept current and available to the public health authorities. The name of any parent or guardian who neglects or refuses to permit his child to be immunized against diseases as required by rules and regulations promulgated hereunder shall be reported by the school superintendent to the director of the health services division [public health division] of the health and environment department [department of health].

History: 1953 Comp., § 12-3-4.4, enacted by Laws 1959, ch. 329, § 4; 1975, ch. 25, § 2; 1977, ch. 253, § 22.

24-5-5. Who may immunize; who must pay.

The immunization required by Chapter 24, Article 5 NMSA 1978 may be done by any health care provider who holds a license or certificate pursuant to state law that authorizes him to immunize. If the parents are unable to pay, the immunization shall be provided by the public health division of the department of health. The department shall undertake every effort to obtain federal funding to implement the department's immunization program. No public health employee may receive any fee for immunization service if the service is compensated for by the public health division. Local school boards may contribute toward the cost of materials and supplies for immunizations.

History: 1953 Comp., § 12-3-4.5, enacted by Laws 1959, ch. 329, § 5; 1977, ch. 253, § 23; 1998, ch. 26, § 2.

24-5-6. Penalty.

Violation of any provisions relating to the immunization of school children is a misdemeanor.

History: 1953 Comp., § 12-3-4.6, enacted by Laws 1959, ch. 329, § 6.

24-5-7. Immunization registry; creation.

The department of health, in conjunction with the human services department [health care authority department], shall establish and maintain a state immunization registry. The registry shall be a single repository of accurate, complete and current immunization records to aid, coordinate and promote effective and cost-efficient disease prevention and control efforts.

History: Laws 2004, ch. 45, § 2.

24-5-8. Reporting.

Physicians, nurses, pharmacists and other health care providers shall report on immunization to the immunization registry unless the patient, or the patient's guardian if the patient is a minor, refuses to allow reporting of this information.

History: Laws 2004, ch. 45, § 3; 2005, ch. 45, §1; 2013, ch. 93, § 1.

24-5-9. Access.

Access to the information in the immunization registry shall be limited to primary care physicians, nurses, pharmacists, managed care organizations, school nurses and other appropriate health care providers or public health entities as determined by the secretary of health; provided that a managed care organization shall be entitled to access information only for its enrollees.

History: Laws 2004, ch. 45, § 4; 2005, ch. 45, §2.

24-5-10. Use.

The information contained in the immunization registry shall be used for the following purposes:

A. to ensure that the registrants receive all recommended immunizations in a timely manner by providing access to the registrant's immunization record;

B. to improve immunization rates by facilitating notice to registrants of overdue or upcoming immunizations; and

C. to control communicable diseases by assisting in the identification of individuals who require immediate immunization in the event of a disease outbreak.

History: Laws 2004, ch. 45, § 5.

24-5-11. Rules.

The secretary of health shall adopt rules for the immunization registry pursuant to the Immunization Act concerning the following:

A. the implementation and maintenance of the registry;

B. requirements for content and submission of reports of immunization to the registry;

C. procedures for the patient, or the patient's parent or guardian if the patient is a minor, to decline to participate in the registry;

D. procedures for the registrant, or the registrant's parent or guardian if the registrant is a minor, to review and correct information contained in the registry;

E. procedures for the registrant, or the registrant's parent or guardian if the registrant is a minor, to withdraw consent for participation at any time and to remove information from the registry;

F. limits on and methods of access to the registry by those authorized to gain access; and

G. procedures for managed care organizations to obtain summary statistics of immunization information on managed care organization members from the registry.

History: Laws 2004, ch. 45, § 6.

24-5-12. Obligations.

Nothing in the immunization registry is intended to affect the obligations of persons to have their children immunized pursuant to the Immunization Act.

History: Laws 2004, ch. 45, § 7.

24-5-13. Rights.

Nothing in the Immunization Act shall preclude the right of the patient, or the patient's parent or guardian if the patient is a minor, to claim exemption from immunization as defined in Section 24-5-3 NMSA 1978; nor shall anything in the Immunization Act require such patient to be included in the immunization registry if the

patient, or the patient's parent or guardian if the patient is a minor, objects on any grounds, including that such registry conflicts with the religious belief of the patient, or the patient's parent or guardian if the patient is a minor.

History: Laws 2004, ch. 45, § 8.

24-5-14. Repealed.

History: Laws 2004, ch. 45, § 9; repealed by Laws 2017, ch. 87, § 31.

24-5-15. Liability.

Any person reporting, receiving, using or disclosing information to or from the immunization registry as authorized by the Immunization Act or by any rule adopted pursuant to that act shall not be liable for civil damages of any kind connected with such submission, use or disclosure of immunization information.

History: Laws 2004, ch. 45, § 10.

ARTICLE 5A
Vaccine Purchasing

24-5A-1. Short title.

This act [24-5A-1 to 24-5A-9 NMSA 1978] may be cited as the "Vaccine Purchasing Act".

History: Laws 2015, ch. 5, § 1.

24-5A-2. Definitions.

As used in the Vaccine Purchasing Act:

A. "advisory committee on immunization practices" means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States, established under Section 222 of the federal Public Health Service Act;

B. "department" means the department of health;

C. "fund" means the vaccine purchasing fund;

D. "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents under the Employee

Retirement Income Security Act of 1974 directly or through insurance, reimbursement or other means;

E. "health insurance coverage" means benefits consisting of medical care provided directly or through insurance or reimbursement or other means under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

F. "health insurer" means any entity subject to regulation by the office of superintendent of insurance that:

(1) provides or is authorized to provide health insurance or health benefit plans;

(2) administers health insurance or health benefit coverage; or

(3) otherwise provides a plan of health insurance or health benefits;

G. "insured child" means a child under the age of nineteen who is eligible to receive health insurance coverage from a health insurer or medical care pursuant to a group health plan;

H. "office of superintendent" means the office of superintendent of insurance;

I. "policy" means any contract of health insurance between a health insurer and the insured and all clauses, riders, endorsements and parts thereof;

J. "provider" means an individual or organization licensed, certified or otherwise authorized or permitted by law to provide vaccinations to insured children; and

K. "vaccines for children program" means the federally funded program that provides vaccines at no cost to eligible children pursuant to Section 1928 of the federal Social Security Act.

History: Laws 2015, ch. 5, § 2.

24-5A-3. Statewide vaccine purchasing program.

A. The department shall establish and administer a statewide vaccine purchasing program to:

(1) expand access to childhood immunizations recommended by the advisory committee on immunization practices;

(2) maintain and improve immunization rates;

(3) facilitate the acquisition by providers of vaccines for childhood immunizations recommended by the advisory committee on immunization practices; and

(4) leverage public and private funding and resources for the purchase, storage and distribution of vaccines for childhood immunizations recommended by the advisory committee on immunization practices.

B. The department shall:

(1) purchase vaccines for all children in New Mexico, including children eligible for the vaccines for children program and insured children;

(2) invoice each health insurer and group health plan to reimburse the department for the cost of vaccines provided directly or indirectly by the department to such health insurer's or group health plan's insured children;

(3) maintain a list of registered providers who receive vaccines for insured children that are purchased by the state and provide such list to each health insurer and group health plan with every invoice;

(4) report the failure of a health insurer to reimburse the department within thirty days of the date of the invoice to the office of superintendent;

(5) report the failure of a health insurer or group health plan to reimburse the department within thirty days of the date of the invoice to the office of the attorney general for collection; and

(6) credit all receipts collected from health insurers and group health plans pursuant to the Vaccine Purchasing Act to the fund.

C. No later than July 1, 2015 and July 1 of each year thereafter, the department shall estimate the amount to be expended annually by the department to purchase, store and distribute vaccines recommended by the advisory committee on immunization practices to all insured children in the state, including a reserve of ten percent of the amount estimated.

D. No later than September 1, 2015 and each quarter thereafter, the department shall invoice each health insurer and each group health plan for one-fourth of its proportionate share of the estimated amount and reserve pursuant to Subsection C of this section, calculated pursuant to Subsection B of Section 6 [24-5A-6 NMSA 1978] of the Vaccine Purchasing Act.

E. The department may update its estimated amount to be expended annually and its reserve to take into account increases or decreases in the cost of vaccines or the costs of additional vaccines that the department determines should be included in the

statewide vaccine purchasing program and adjust the amount invoiced to each health insurer and group health plan the following quarter.

History: Laws 2015, ch. 5, § 3.

24-5A-4. Vaccine purchasing fund.

A. The "vaccine purchasing fund" is created in the state treasury. The fund consists of amounts reimbursed to the state by health insurers and group health plans pursuant to the Vaccine Purchasing Act and of appropriations from, and transfers made to, the fund. Money in the fund shall be expended only for the purposes specified in the Vaccine Purchasing Act, by warrant issued by the secretary of finance and administration pursuant to vouchers approved by the secretary of health.

B. Money from the fund may be appropriated to the department to be expended only as authorized in Section 5 [24-5A-5 NMSA 1978] of the Vaccine Purchasing Act.

C. The fund shall be audited in the same manner as other state funds are audited, and all records of payments made from the fund shall be open to the public.

D. Any balance remaining in the fund shall not revert or be transferred to any other fund at the end of a fiscal year.

E. Money in the fund shall be invested by the state investment officer in accordance with the limitations in Article 12, Section 7 of the constitution of New Mexico. Income from investment of the fund shall be credited to the fund.

History: Laws 2015, ch. 5, § 4.

24-5A-5. Authorized uses of the vaccine purchasing fund.

A. The fund shall be used for the purchase, storage and distribution of vaccines, as recommended by the advisory committee on immunization practices, for insured children who are not eligible for the vaccines for children program.

B. The department shall credit any balance remaining in the fund at the end of the fiscal year toward the department's purchase of vaccines the following year; provided that the department maintains a reserve of ten percent of the amount estimated to be expended in the following year.

C. The fund shall not be used:

(1) for the purchase, storage and distribution of vaccines for children who are eligible for the vaccines for children program;

(2) for administrative expenses associated with the statewide vaccine purchasing program; or

(3) to pass through a federally negotiated discount pursuant to 42 U.S.C. 1396s.

History: Laws 2015, ch. 5, § 5.

24-5A-6. Reporting.

A. No later than one hundred twenty days following the enactment of the Vaccine Purchasing Act, the office of superintendent shall:

(1) promulgate rules requiring each health insurer and group health plan to report the number of children it insured who were under the age of nineteen as of December 31, 2014 and to annually report the number of children it insures who will be under the age of nineteen as of December 31 of each subsequent year to the office of superintendent, excluding from such reports children who are enrolled in medicaid or in any medical assistance program administered by the department or the human services department [health care authority department] and children who are American Indian or Alaska Natives; and

(2) for each health insurer or group health plan, provide the department with the number of insured children reported by such health insurer or group health plan pursuant to Paragraph (1) of this subsection.

B. Each health insurer and group health plan shall reimburse the department for the cost of vaccines for childhood immunizations purchased by the state for the benefit of such health insurer's or group health plan's insured children according to such health insurer's or group health plan's policy obligations and in accordance with health insurance coverage requirements under state and federal law. The amount reimbursed by each health insurer or group health plan shall be a fraction, the denominator of which is the total number of insured children reported by all health insurers and group health plans pursuant to Subsection A of this section and the numerator of which is the number of insured children reported by such health insurer or group health plan pursuant to Subsection A of this section multiplied by the total amount as determined by the department pursuant to Subsection B of Section 3 [24-5A-3 NMSA 1978] of the Vaccine Purchasing Act.

C. A health insurer's or group health plan's reimbursement to the department pursuant to the Vaccine Purchasing Act shall be deemed payment for clinical services and activities to promote health care quality for the purpose of calculating a health insurer's or group health plan's medical loss ratio.

History: Laws 2015, ch. 5, § 6.

24-5A-7. Appeal; penalties.

A. A health insurer aggrieved pursuant to the Vaccine Purchasing Act may appeal as provided in Section 59A-4-20 NMSA 1978.

B. A health insurer or group health plan that fails to file a report required by the office of superintendent pursuant to Subsection A of Section 6 [24-5A-6 NMSA 1978] of the Vaccine Purchasing Act shall pay a late filing fee of five hundred dollars ($500) per day for each day from the date the report was due.

C. The office of superintendent may require a health insurer or group health plan subject to the Vaccine Purchasing Act to produce records that were used to prepare the report required under Subsection A of Section 6 of the Vaccine Purchasing Act. If the office of superintendent determines that there is other than a good faith discrepancy between the number of insured children reported and the number of insured children that should have been reported, the health insurer or group health plan shall pay a civil penalty of five hundred dollars ($500) for each report filed for which the office of superintendent determines there is such a discrepancy.

D. Failure of a health insurer or group health plan to make timely payment of an amount invoiced pursuant to Subsection D of Section 3 [24-5A-3 NMSA 1978] of the Vaccine Purchasing Act shall subject the health insurer or group health plan to a civil penalty of five hundred dollars ($500) for each day from the date the payment is due.

History: Laws 2015, ch. 5, § 7.

24-5A-8. Powers and authority.

The department and the office of superintendent shall promulgate and enforce such rules as may be necessary to carry out the provisions of the Vaccine Purchasing Act.

History: Laws 2015, ch. 5, § 8.

24-5A-9. Applicability.

The provisions of the Vaccine Purchasing Act:

A. do not apply to an entity that only issues policies, certificates or subscriber contracts within New Mexico that are limited to a specific disease; hospital confinement; indemnity; accident-only; credit; dental; vision; medicare supplement; long-term care; disability income insurance; student health benefits-only coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; nonrenewable short-term coverage issued for a period of twelve months or less; medicaid; or any medical assistance program administered by the department or the human services department [health care authority department]; and

B. apply to policies, plans, contracts and certificates delivered or issued for delivery or renewed, extended or amended in this state on or after January 1, 2015.

History: Laws 2015, ch. 5, § 9.

ARTICLE 6
Anatomical Gifts (Repealed.)

24-6-1 to 24-6-11. Repealed.

ARTICLE 6A
Uniform Anatomical Gift Act (Repealed, Recompiled.)

24-6A-1. Repealed.

History: Laws 1995, ch. 116, § 1; 2000, ch. 54, § 1; repealed by Laws 2007, ch. 323, § 35.

24-6A-2. Repealed.

History: Laws 1995, ch. 116, § 2; 2000, ch. 54, § 2; repealed by Laws 2007, ch. 323, § 35.

24-6A-3. Repealed.

History: Laws 1995, ch. 116, § 3; 2000, ch. 54, § 3; repealed by Laws 2007, ch. 323, § 35.

24-6A-4. Repealed.

History: Laws 1995, ch. 116, § 4; repealed by Laws 2007, ch. 323, § 35.

24-6A-5. Repealed.

History: Laws 1995, ch. 116, § 5; 2000, ch. 54, § 4; 2002, ch. 42, § 1; repealed by Laws 2007, ch. 323, § 35.

24-6A-6. Repealed.

History: Laws 1995, ch. 116, § 6; 2002, ch. 42, § 2; repealed by Laws 2007, ch. 323, § 35.

24-6A-6.1. Repealed.

History: Laws 2000, ch. 54, § 8; repealed by Laws 2007, ch. 323, § 35.

24-6A-7. Repealed.

History: Laws 1995, ch. 116, § 7; repealed by Laws 2007, ch. 323, § 35.

24-6A-7.1. Recompiled.

History: Laws 2002, ch. 42, § 3; recompiled as § 24-6B-7.1 by Laws 2007, ch. 323, § 28.

24-6A-8. Repealed.

History: Laws 1995, ch. 116, § 8; repealed by Laws 2007, ch. 323, § 35.

24-6A-9. Repealed.

History: Laws 1995, ch. 116, § 9; repealed by Laws 2007, ch. 323, § 35.

24-6A-9.1. Recompiled.

History: Laws 2000, ch. 54, § 7; recompiled as § 24-6B-9.1 by Laws 2007, ch. 323, § 29.

24-6A-9.2. Recompiled.

History: Laws 2000, ch. 54, § 6; recompiled as § 24-6B-9.2 by Laws 2007, ch. 323, § 30.

24-6A-10. Repealed.

History: Laws 1995, ch. 116, § 10; repealed by Laws 2007, ch. 323, § 35.

24-6A-11. Repealed.

History: Laws 1995, ch. 116, § 11; repealed by Laws 2007, ch. 323, § 35.

24-6A-12. Repealed.

History: Laws 1995, ch. 116, § 12; repealed by Laws 2007, ch. 323, § 35.

24-6A-13. Repealed.

History: Laws 1995, ch. 116, § 13; repealed by Laws 2007, ch. 323, § 35.

24-6A-14. Repealed.

History: Laws 1995, ch. 116, § 14; repealed by Laws 2007, ch. 323, § 35.

24-6A-15. Repealed.

History: Laws 1995, ch. 116, § 15; 2000, ch. 54, § 5; repealed by Laws 2007, ch. 323, § 35.

ARTICLE 6B
Jonathan Spradling Revised Uniform Anatomical Gift Act

24-6B-1. Short title.

Chapter 24, Article 6B NMSA 1978 may be cited as the "Jonathan Spradling Revised Uniform Anatomical Gift Act".

History: Laws 2007, ch. 323, § 1; 2023, ch. 171, § 1.

24-6B-2. Definitions.

As used in the Jonathan Spradling Revised Uniform Anatomical Gift Act:

A. "adult" means an individual who is at least sixteen years of age;

B. "agent" means an individual:

(1) authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

(2) expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal;

C. "anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research or education;

D. "decedent" means a deceased individual whose body or part is or may be the source of an anatomical gift. "Decedent" includes a stillborn infant and, subject to restrictions imposed by law other than the Jonathan Spradling Revised Uniform Anatomical Gift Act, a fetus but not including a fetus that is the subject of an induced abortion;

E. "disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent or guardian of the individual who makes, amends, revokes or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. "Disinterested witness" does not include a person to which an anatomical gift could pass pursuant to Section 11 [24-6B-11 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act;

F. "document of gift" means a donor card or other record used to make an anatomical gift. "Document of gift" includes a statement or symbol on a driver's license, identification card or donor registry;

G. "donor" means an individual whose body or part is the subject of an anatomical gift;

H. "donor registry" means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts;

I. "driver's license" means a license or permit issued by the motor vehicle division of the taxation and revenue department to operate a vehicle, whether or not conditions are attached to the license or permit;

J. "eye bank" means a person that is licensed, accredited or regulated pursuant to federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of human eyes or portions of human eyes;

K. "guardian" means a person appointed by a court to make decisions regarding the support, care, education, health or welfare of an individual. "Guardian" does not include a guardian ad litem;

L. "hospital" means a facility licensed as a hospital pursuant to the law of any state or a facility operated as a hospital by the United States, a state or a subdivision of a state;

M. "identification card" means an identification card issued by the motor vehicle division of the taxation and revenue department;

N. "know" means to have actual knowledge;

O. "minor" means an individual who is under eighteen years of age;

P. "organ procurement organization" means a person designated by the secretary of the federal department of health and human services as an organ procurement organization;

Q. "parent" means a parent whose parental rights have not been terminated;

R. "part" means an organ, an eye or tissue of a human being. "Part" does not include the whole body;

S. "person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency or instrumentality, or any other legal or commercial entity;

T. "physician" means an individual authorized to practice medicine or osteopathy pursuant to the law of any state;

U. "power of attorney for health care" includes an advance health-care directive as defined in the Uniform Health-Care Decisions Act [Chapter 24, Article 7A NMSA 1978];

V. "procurement organization" means an eye bank, organ procurement organization or tissue bank;

W. "prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research or education. "Prospective donor" does not include an individual who has made a refusal;

X. "reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift;

Y. "recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted;

Z. "record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form;

AA. "refusal" means a record created pursuant to Section 7 [24-6B-7 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part;

BB. "sign" means, with the present intent to authenticate or adopt a record:

(1) to execute or adopt a tangible symbol; or

(2) to attach to or logically associate with the record an electronic symbol, sound or process;

CC. "state" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands or any territory or insular possession subject to the jurisdiction of the United States;

DD. "technician" means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited or regulated pursuant to federal or state law. "Technician" includes an enucleator;

EE. "tissue" means a portion of the human body other than an organ or an eye. "Tissue" does not include blood unless the blood is donated for the purpose of research or education;

FF."tissue bank" means a person that is licensed, accredited or regulated pursuant to federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of tissue; and

GG. "transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

History: Laws 2007, ch. 323, §2.

24-6B-3. Applicability.

The Jonathan Spradling Revised Uniform Anatomical Gift Act applies to an anatomical gift or amendment to, revocation of or refusal to make an anatomical gift, whenever made.

History: Laws 2007, ch. 323, § 3.

24-6B-4. Who may make anatomical gift before donor's death.

Subject to the provisions of Section 8 [24-6B-8 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research or education in the manner provided in Section 5 [24-6B-5 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act by:

A. the donor, if the donor is an adult or if the donor is a minor and is:

(1) emancipated; or

(2) authorized pursuant to state law to apply for an instruction permit because the donor is at least fifteen years of age;

B. an agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

C. a parent of the donor, if the donor is an unemancipated minor; or

D. the donor's guardian.

History: Laws 2007, ch. 323, § 4.

24-6B-5. Manner of making anatomical gift before donor's death.

A. A donor may make an anatomical gift:

(1) by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's license or identification card;

(2) in a will;

(3) during a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness; or

(4) as provided in Subsection B of this section.

B. A donor or other person authorized to make an anatomical gift pursuant to Section 4 [24-6B-4 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and shall:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) state that it has been signed and witnessed as provided in Paragraph (1) of this subsection.

C. Revocation, suspension, expiration or cancellation of a driver's license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

D. An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the anatomical gift.

History: Laws 2007, ch. 323, § 5.

24-6B-6. Amending or revoking anatomical gift before donor's death.

A. Subject to the provisions of Section 8 [24-6B-8 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, a donor or other person authorized to make an anatomical gift pursuant to Section 4 [24-6B-4 NMSA 1978] of that act may amend or revoke an anatomical gift by:

(1) a record signed by:

(a) the donor;

(b) the other person; or

(c) subject to the provisions of Subsection B of this section, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(2) a later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

B. A record signed pursuant to Subparagraph (c) of Paragraph (1) of Subsection A of this section shall:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) state that it has been signed and witnessed as provided in Paragraph (1) of this subsection.

C. Subject to the provisions of Section 8 [24-6B-8 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, a donor or other person authorized to make an anatomical gift pursuant to Section 4 of that act may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

D. A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

E. A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in Subsection A of this section.

History: Laws 2007, ch. 323, § 6.

24-6B-7. Refusal to make anatomical gift; effect of refusal.

A. An individual may refuse to make an anatomical gift of the individual's body or part by:

(1) a record signed by:

(a) the individual; or

(b) subject to the provisions of Subsection B of this section, another individual acting at the direction of the individual if the individual is physically unable to sign;

(2) the individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(3) any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

B. A record signed pursuant to Subparagraph (b) of Paragraph (1) of Subsection A of this section shall:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(2) state that it has been signed and witnessed as provided in Paragraph (1) of this subsection.

C. An individual who has made a refusal may amend or revoke the refusal:

(1) in the manner provided in Subsection A of this section for making a refusal;

(2) by subsequently making an anatomical gift pursuant to Section 5 [24-6B-5 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act that is inconsistent with the refusal; or

(3) by destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

D. Except as otherwise provided in Subsection H of Section 8 [24-6B-8 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars all other persons from making an anatomical gift of the individual's body or part.

History: Laws 2007, ch. 323, § 7.

24-6B-7.1. Document of gift as a legal document.

A document of gift constitutes a legal document and has sufficient legal authority to be accepted by a designated or undesignated donee of anatomical gifts pursuant to the Jonathan Spradling Revised Uniform Anatomical Gift Act.

History: Laws 2002, ch. 42, § 3; recompiled and amended by Laws 2007, ch. 323, § 28.

24-6B-8. Preclusive effect of anatomical gift, amendment or revocation.

A. Except as otherwise provided in Subsection G of this section and subject to the provisions of Subsection F of this section, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part pursuant to Section 5 [24-6B-5 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act or an amendment to an anatomical gift of the donor's body or part pursuant to Section 6 [24-6B-6 NMSA 1978] of that act.

B. A donor's revocation of an anatomical gift of the donor's body or part pursuant to Section 6 of the Jonathan Spradling Revised Uniform Anatomical Gift Act is not a refusal and does not bar another person specified in Section 4 [24-6B-4 NMSA 1978] or 9 [24-6B-9 NMSA 1978] of that act from making an anatomical gift of the donor's body or part pursuant to Section 5 or 10 [24-6B-10 NMSA 1978] of that act.

C. If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part pursuant to Section 5 of the Jonathan Spradling Revised Uniform Anatomical Gift Act or an amendment to an anatomical gift of the donor's body or part pursuant to Section 6 of that act, another person may not make, amend or revoke the gift of the donor's body or part pursuant to Section 10 of that act.

D. A revocation of an anatomical gift of a donor's body or part pursuant to Section 6 of the Jonathan Spradling Revised Uniform Anatomical Gift Act by a person other than the donor does not bar another person from making an anatomical gift of the body or part pursuant to Section 5 or 10 of that act.

E. In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift pursuant to Section 4 of the Jonathan Spradling Revised Uniform Anatomical Gift Act, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

F. In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift pursuant to Section 4 of the Jonathan Spradling Revised Uniform Anatomical Gift Act, an anatomical gift of a part for one or more of the purposes set forth in Section 4 of that act is not a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or any other person pursuant to Section 5 or 10 of that act.

G. If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

H. If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

History: Laws 2007, ch. 323, § 8.

24-6B-9. Who may make anatomical gift of decedent's body or part.

A. Subject to the provisions of Subsections B and C of this section and unless barred by Section 7 [24-6B-7 NMSA 1978] or 8 [24-6B-8 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, an anatomical gift of a decedent's body or part for purpose of transplantation, therapy, research or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(1) an agent of the decedent at the time of death who could have made an anatomical gift pursuant to Subsection B of Section 4 [24-6B-4 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act immediately before the decedent's death;

(2) the spouse of the decedent unless legally separated or unless there is a pending action for annulment, divorce, dissolution of marriage or separation;

(3) adult children of the decedent;

(4) parents of the decedent;

(5) adult siblings of the decedent;

(6) adult grandchildren of the decedent;

(7) grandparents of the decedent;

(8) an adult who exhibited special care and concern for the decedent;

(9) the persons who were acting as the guardians of the person of the decedent at the time of death; and

(10) any other person having the authority to dispose of the decedent's body.

B. If there is more than one member of a class listed in Paragraphs (1), (3), (4), (5), (6), (7) and (9) of Subsection A of this section entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass pursuant to Section 11 [24-6B-11 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

C. A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class pursuant to Subsection A of this section is reasonably available to make or to object to the making of an anatomical gift.

History: Laws 2007, ch. 323, § 9.

24-6B-9.1. Identification of potential donors.

A. Each hospital in New Mexico, with the concurrence of its medical staff, shall develop by July 1, 2000 a protocol for identifying potential donors. The protocol shall be developed in collaboration with a procurement organization. The protocol shall provide that at or near the time of a patient's death and prior to the removal of life support, the hospital shall contact a procurement organization to determine the suitability of the patient as a donor. The person designated by the hospital to contact the procurement organization shall have the following information available prior to making the contact:

(1) the patient's identifier number;

(2) the patient's age;

(3) the cause of death; and

(4) any past medical history available.

B. The procurement organization shall determine the suitability for donation. If the procurement organization determines that donation is not appropriate based on established medical criteria, that determination shall be noted by hospital personnel on the patient's record and no further action is necessary.

C. If the procurement organization determines that the patient is a suitable candidate for donation, the procurement organization shall initiate donor proceedings by making a reasonable search for a document of gift or other information identifying the patient as a donor or as a person who has refused to make an anatomical gift.

D. The hospital must have and implement written protocols that:

(1) incorporate an agreement with a procurement organization under which the hospital must notify, in a timely manner, the procurement organization or a third party designated by the procurement organization of patients whose deaths are imminent and prior to the removal of life support from a patient who has died in the hospital;

(2) ensure that the retrieval, processing, preservation, storage and distribution of tissues and eyes does not interfere with vascular organ procurement;

(3) ensure that the family of each potential donor is informed of its options to donate organs, tissues or eyes or to decline to donate. The person designated by the hospital to initiate the request to the family must be a procurement organization employee or a designated requester;

(4) encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of potential donors; and

(5) ensure that the hospital works cooperatively with the procurement organization in educating hospital staff on donation issues, reviewing death records to improve identification of potential donors and maintaining potential donors while necessary testing and placement of anatomical gifts take place.

E. Every hospital in the state shall establish a committee to develop and implement its organ and tissue donation policy and procedure to assist its staff in identifying and evaluating terminal patients who may be suitable organ or tissue donors. The committee shall include members of the administrative, medical and nursing staffs and shall appoint a member to act as a liaison between the hospital and the state procurement organization.

History: Laws 2000, ch. 54, § 7; recompiled and amended by Laws 2007, ch. 323, § 29.

24-6B-9.2. Death record reviews.

Every hospital shall work jointly with the appropriate procurement organization to conduct death record reviews at least annually. The procurement organization shall compile the results of the death record reviews and provide a report to the department of health by September 1 of each year; provided that the report to the department shall not identify hospitals, donors or recipients.

History: Laws 2000, ch. 54, § 6; recompiled and amended by Laws 2007, ch. 323, § 30.

24-6B-10. Manner of making, amending or revoking anatomical gift of decedent's body or part.

A. A person authorized to make an anatomical gift pursuant to Section 9 [24-6B-9 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

B. Subject to the provisions of Subsection C of this section, an anatomical gift by a person authorized pursuant to Section 9 of the Jonathan Spradling Revised Uniform Anatomical Gift Act may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized pursuant to Section 9 of that act may be:

(1) amended only if a majority of the reasonably available members agree to the amending of the gift; or

(2) revoked only if a majority of the reasonably available members agree to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

C. A revocation pursuant to Subsection B of this section is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital or physician or technician knows of the revocation.

History: Laws 2007, ch. 323, § 10.

24-6B-11. Persons that may receive anatomical gift; purpose of anatomical gift.

A. An anatomical gift may be made to the following persons named in the document of gift:

(1) a hospital; accredited medical school, dental school, college or university; organ procurement organization; or other appropriate person, for research or education;

(2) subject to the provisions of Subsection B of this section, an individual designated by the person making the anatomical gift if the individual is the recipient of the part; and

(3) an eye bank or tissue bank.

B. If an anatomical gift to an individual pursuant to Paragraph (2) of Subsection A of this section cannot be transplanted into the individual, the part passes in accordance with Subsection G of this section in the absence of an express, contrary indication by the person making the anatomical gift.

C. If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in Subsection A of this section but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) if the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank;

(2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank;

(3) if the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and

(4) if the part is an organ, an eye or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

D. For the purpose of Subsection C of this section, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift shall be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

E. If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in Subsection A of this section and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with Subsection G of this section.

F. If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor", "organ donor" or "body donor", or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy and the gift passes in accordance with Subsection G of this section.

G. For purposes of Subsections B, E and F of this section, the following rules apply:

(1) if the part is an eye, the gift passes to the appropriate eye bank;

(2) if the part is tissue, the gift passes to the appropriate tissue bank; and

(3) if the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

H. An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift pursuant to Paragraph (2) of Subsection A of this section, passes to the organ procurement organization as custodian of the organ.

I. If an anatomical gift does not pass pursuant to Subsections A through H of this section or the decedent's body or part is not used for transplantation, therapy, research or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

J. A person may not accept an anatomical gift if the person knows that the gift was not effectively made pursuant to Section 24-6B-5 or 24-6B-10 NMSA 1978 or if the person knows that the decedent made a refusal pursuant to Section 24-6B-7 NMSA 1978 that was not revoked. For purposes of this subsection, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

K. Except as otherwise provided in Paragraph (2) of Subsection A of this section, nothing in the Jonathan Spradling Revised Uniform Anatomical Gift Act affects the allocation of organs for transplantation or therapy.

L. An individual's participation in the state's medical cannabis program established pursuant to the Lynn and Erin Compassionate Use Act shall not in itself constitute grounds for refusing to allow that individual to receive an anatomical gift.

History: Laws 2007, ch. 323, § 11; 2019, ch. 247, § 13.

24-6B-12. Search and notification.

A. The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) a law enforcement officer, firefighter, paramedic or other emergency rescuer finding the individual; and

(2) if no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

B. If a document of gift or a refusal to make an anatomical gift is located by the search required by Paragraph (1) of Subsection A of this section and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

C. A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

History: Laws 2007, ch. 323, § 12.

24-6B-13. Delivery of document of gift not required; right to examine.

A. A document of gift need not be delivered during the donor's lifetime to be effective.

B. Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass pursuant to Section 11 [24-6B-11 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act.

History: Laws 2007, ch. 323, § 13.

24-6B-14. Rights and duties of procurement organization and others.

A. When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the motor vehicle division of the taxation and revenue department and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

B. A procurement organization shall be allowed reasonable access to information in the records of the motor vehicle division of the taxation and revenue department to ascertain whether an individual at or near death is a donor.

C. When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

D. Unless prohibited by law other than the Jonathan Spradling Revised Uniform Anatomical Gift Act, at any time after a donor's death, the person to which a part passes pursuant to Section 11 [24-6B-11 NMSA 1978] of that act may conduct any reasonable

examination necessary to ensure the medical suitability of the body or part for its intended purpose.

E. Unless prohibited by law other than the Jonathan Spradling Revised Uniform Anatomical Gift Act, an examination pursuant to Subsection C or D of this section may include an examination of all medical and dental records of the donor or prospective donor.

F. Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

G. Upon referral by a hospital pursuant to Subsection A of this section, a procurement organization shall make a reasonable search for any person listed in Section 9 [24-6B-9 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended or revoked, it shall promptly advise the other person of all relevant information.

H. Subject to the provisions of Subsection I of Section 11 and Section 23 [24-6B-23 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, the rights of the person to which a part passes pursuant to Section 11 of that act are superior to the rights of all others with respect to the part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and the Jonathan Spradling Revised Uniform Anatomical Gift Act, a person that accepts an anatomical gift of an entire body may allow embalming, burial or cremation, and use of remains in a funeral service. If the gift is of a part, the person to which the part passes pursuant to Section 11 of the Jonathan Spradling Revised Uniform Anatomical Gift Act, upon the death of the donor and before embalming, burial or cremation, shall cause the part to be removed without unnecessary mutilation.

I. Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

J. A physician or technician may remove a donated part from the body of a donor that the physician or technician is qualified to remove.

History: Laws 2007, ch. 323, § 14.

24-6B-15. Coordination of procurement and use.

Each hospital in this state shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

History: Laws 2007, ch. 323, § 15.

24-6B-16. Sale or purchase of parts prohibited.

A. Except as otherwise provided in Subsection B of this section, a person who for valuable consideration, knowingly purchases or sells a part for transplantation or therapy if removal of a part from an individual is intended to occur after the individual's death commits a third degree felony and upon conviction is subject to a fine not exceeding five thousand dollars ($5,000) or imprisonment not exceeding six years, or both.

B. A person may charge a reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation or disposal of a part.

History: Laws 2007, ch. 323, § 16.

24-6B-17. Other prohibited acts.

A person who, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces or obliterates a document of gift, an amendment or revocation of a document of gift, or a refusal, commits a third degree felony and upon conviction is subject to a fine not exceeding five thousand dollars ($5,000) or imprisonment not exceeding six years, or both.

History: Laws 2007, ch. 323, § 17.

24-6B-18. Immunity.

A. A person that acts in accordance with the Jonathan Spradling Revised Uniform Anatomical Gift Act or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution or administrative proceeding.

B. Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

C. In determining whether an anatomical gift has been made, amended or revoked pursuant to the Jonathan Spradling Revised Uniform Anatomical Gift Act, a person may rely upon representations of an individual listed in Paragraph (2), (3), (4), (5), (6), (7) or (8) of Subsection A of Section 9 [24-6B-9 NMSA 1978] of that act relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

History: Laws 2007, ch. 323, § 18.

24-6B-19. Law governing validity; choice of law as to execution of document of gift; presumption of validity.

A. A document of gift is valid if executed in accordance with:

(1) the Jonathan Spradling Revised Uniform Anatomical Gift Act;

(2) the laws of the state or country where it was executed; or

(3) the laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence or was a national at the time the document of gift was executed.

B. If a document of gift is valid pursuant to this section, the law of this state governs the interpretation of the document of gift.

C. A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

History: Laws 2007, ch. 323, § 19.

24-6B-20. Donor registry.

A. The motor vehicle division of the taxation and revenue department shall establish a donor registry pursuant to the provisions of Subsection B of Section 66-5-10 NMSA 1978.

B. The motor vehicle division of the taxation and revenue department shall cooperate with a person that administers any donor registry that this state establishes, contracts for or recognizes for the purpose of transferring to the donor registry all relevant information regarding a donor's making, amendment to or revocation of an anatomical gift.

C. A donor registry shall:

(1) allow a donor or other person authorized pursuant to Section 4 [24-6B-4 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act to include on the donor registry a statement or symbol that the donor has made, amended or revoked an anatomical gift;

(2) be accessible to a procurement organization to allow it to obtain relevant information on the donor registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended or revoked an anatomical gift; and

(3) be accessible for purposes of Paragraphs (1) and (2) of this subsection seven days a week on a twenty-four-hour basis.

D. Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor or person who made the anatomical gift for any purpose other than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended or revoked an anatomical gift.

E. This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the state. Any such registry shall comply with the provisions of Subsections C and D of this section.

History: Laws 2007, ch. 323, § 20.

24-6B-21. Effect of anatomical gift on advance health-care directive.

A. As used in this section:

(1) "advance health-care directive" means a power of attorney for health care, a health-care directive made pursuant to the provisions of the Uniform Health-Care Decisions Act [Chapter 24, Article 7A NMSA 1978] or a record signed by a prospective donor containing the prospective donor's direction concerning a health-care decision for the prospective donor;

(2) "declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor; and

(3) "health-care decision" means any decision made regarding the health care of the prospective donor.

B. If a prospective donor has a declaration or advance health-care directive, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor, unless the declaration expressly provides to the contrary.

History: Laws 2007, ch. 323, § 21.

24-6B-22. Cooperation between office of the state medical investigator and procurement organization.

A. The office of the state medical investigator shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research or education.

B. If the office of the state medical investigator receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose body is under the jurisdiction of the office of the state medical investigator and a post-mortem examination is going to be performed, unless the office of the state medical investigator denies recovery in accordance with Section 23 [24-6B-23 NMSA 1978] of the Jonathan Spradling Revised Uniform Anatomical Gift Act, the office of the state medical investigator or its designee shall conduct a post-mortem examination of the body or the part in a manner and within a period compatible with its preservation for the purposes of the anatomical gift.

C. A part may not be removed from the body of a decedent under the jurisdiction of the office of the state medical investigator for transplantation, therapy, research or education unless the part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the office of the state medical investigator may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This subsection does not preclude the office of the state medical investigator from performing the medico-legal investigation upon the body or parts of a decedent under the jurisdiction of the office of the state medical investigator.

History: Laws 2007, ch. 323, § 22.

24-6B-23. Facilitation of anatomical gift from decedent whose body is under jurisdiction of the office of the state medical investigator.

A. Upon request of a procurement organization, the office of the state medical investigator shall release to the procurement organization the name, contact information and available medical and social history of a decedent whose body is under the jurisdiction of the office of the state medical investigator. If the decedent's body or part is medically suitable for transplantation, therapy, research or education, the office of the state medical investigator shall release post-mortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the post-mortem examination results or other information received from the office of the state medical investigator only if relevant to transplantation or therapy.

B. The office of the state medical investigator may conduct a medico-legal investigation by reviewing all medical records, laboratory test results, x-rays, other diagnostic results and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the office of the state medical investigator that the office of the state medical investigator determines may be relevant to the investigation.

C. A person that has any information requested by the office of the state medical investigator pursuant to Subsection B of this section shall provide that information as expeditiously as possible to allow the office of the state medical investigator to conduct the medico-legal investigation within a period compatible with the preservation of parts for the purpose of transplantation, therapy, research or education.

D. If an anatomical gift has been or might be made of a part of a decedent whose body is under the jurisdiction of the office of the state medical investigator and a post-mortem examination is not required, or the office of the state medical investigator determines that a post-mortem examination is required but that the recovery of the part that is the subject of an anatomical gift will not interfere with the examination, the office of the state medical investigator and the procurement organization shall cooperate in the timely removal of the part from the decedent for the purpose of transplantation, therapy, research or education.

E. If an anatomical gift of a part from the decedent under the jurisdiction of the office of the state medical investigator has been or might be made, but the office of the state medical investigator initially believes that the recovery of the part could interfere with the post-mortem investigation into the decedent's cause or manner of death, the office of the state medical investigator shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the office of the state medical investigator may allow the recovery.

F. Following the consultation pursuant to Subsection E of this section, in the absence of mutually agreed-upon protocols to resolve conflict between the office of the state medical investigator and the procurement organization, if the office of the state medical investigator intends to deny recovery, the office of the state medical investigator or its designee, at the request of the procurement organization, shall attend the removal procedure for the part before making a final determination not to allow the procurement organization to recover the part. During the removal procedure, the office of the state medical investigator or its designee may allow recovery by the procurement organization to proceed, or, if the office of the state medical investigator or its designee reasonably believes that the part may be involved in determining the decedent's cause or manner of death, may deny recovery by the procurement organization.

G. If the office of the state medical investigator or its designee denies recovery pursuant to Subsection F of this section, the office of the state medical investigator or its designee shall:

(1) explain in a record the specific reasons for not allowing recovery of the part;

(2) include the specific reasons in the records of the office of the state medical investigator; and

(3) provide a record with the specific reasons to the procurement organization.

H. If the office of the state medical investigator or its designee allows recovery of a part pursuant to Subsection D, E or F of this section, the procurement organization, upon request, shall cause the physician or technician who removes the part to provide

the office of the state medical investigator with a record describing the condition of the part, a biopsy, a photograph and any other information and observations that would assist in the post-mortem examination.

I. If the office of the state medical investigator or its designee is required to be present at a removal procedure pursuant to Subsection F of this section, upon request the procurement organization requesting the recovery of the part shall reimburse the office of the state medical investigator or its designee for the additional costs incurred in complying with the provisions of Subsection F of this section.

History: Laws 2007, ch. 323, § 23.

24-6B-24. Uniformity of application and construction.

In applying and construing the Jonathan Spradling Revised Uniform Anatomical Gift Act, consideration shall be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

History: Laws 2007, ch. 323, § 24.

24-6B-25. Relation to Electronic Signatures in Global and National Commerce Act.

The Jonathan Spradling Revised Uniform Anatomical Gift Act modifies, limits and supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001 et seq., but does not modify, limit or supersede Section 101(a) of that act, 15 U.S.C. Section 7001, or authorize electronic delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. Section 7003(b).

History: Laws 2007, ch. 323, § 25.

24-6B-26. Discrimination against recipients based on disability prohibited; enforcement.

A. As used in this section:

(1) "covered entity" means an organ procurement organization, hospital, transplant hospital, physician, insurance company or plan or health maintenance organization; and

(2) "disability" means a severe chronic physical or mental impairment that results in substantial functional limitations in one or more of the following areas of major life activity:

(a) self-care;

(b) receptive and expressive language;

(c) learning;

(d) mobility;

(e) self-determination; and

(f) capacity for independent living.

B. The provisions of this section apply to all stages of the transplant process.

C. A covered entity shall not discriminate against a person with a disability in the receipt of an anatomical gift and shall not, solely on the basis of a person's disability:

(1) consider the person ineligible to receive an anatomical gift;

(2) deny transplantation-related services;

(3) refuse to refer the person to an organ procurement organization, transplant hospital or other related specialist for the purpose of being evaluated for or receiving an anatomical gift;

(4) refuse to place an otherwise qualified recipient on an anatomical gift waiting list;

(5) place an otherwise qualified recipient on an anatomical gift waiting list at a lower priority position than the position at which the recipient would have been placed if the recipient did not have a disability; or

(6) refuse insurance coverage for any procedures associated with being evaluated for or receiving an anatomical gift, including post-surgical medical care.

D. A covered entity may take a person's disability into account when making treatment recommendations or decisions only to the extent that the disability has been found by a physician to be medically significant to the provision of the anatomical gift after an individualized evaluation of the person. If a person with a disability has the necessary support system to assist the person in complying with post-surgical medical requirements, a covered entity shall not consider the person's inability to independently comply with post-surgical medical requirements to be medically significant.

E. A person affected by a violation of the provisions of this section may commence a civil action in district court.

F. Nothing in this section is intended to limit or replace available remedies under the federal Americans with Disabilities Act of 1990 or other applicable law.

History: Laws 2023, ch. 171, § 2.

ARTICLE 7
Right to Die (Repealed.)

24-7-1 to 24-7-11. Repealed.

ARTICLE 7A
Uniform Health-Care Decisions

24-7A-1. Definitions.

As used in the Uniform Health-Care Decisions Act:

A. "advance health-care directive" means an individual instruction or a power of attorney for health care made, in either case, while the individual has capacity;

B. "agent" means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power;

C. "capacity" means an individual's ability to understand and appreciate the nature and consequences of proposed health care, including its significant benefits, risks and alternatives to proposed health care and to make and communicate an informed health-care decision. A determination of lack of capacity shall be made only according to the provisions of Section 24-7A-11 NMSA 1978;

D. "emancipated minor" means an individual between the ages of sixteen and eighteen who has been married, who is on active duty in the armed forces or who has been declared by court order to be emancipated;

E. "guardian" means a judicially appointed guardian or conservator having authority to make a health-care decision for an individual;

F. "health care" means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition;

G. "health-care decision" means a decision made by an individual or the individual's agent, guardian or surrogate, regarding the individual's health care, including:

(1) selection and discharge of health-care practitioners and institutions;

(2) approval or disapproval of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate;

(3) directions relating to life-sustaining treatment, including withholding or withdrawing life-sustaining treatment and the termination of life support; and

(4) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care;

H. "health-care institution" means an institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business;

I. "health-care practitioner" means an individual licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession;

J. "individual instruction" means an individual's direction concerning a health-care decision for the individual made while the individual has capacity;

K. "life-sustaining treatment" means any medical treatment or procedure without which the individual is likely to die within a relatively short time, as determined to a reasonable degree of medical certainty by the primary care practitioner;

L. "person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency or instrumentality or any other legal or commercial entity;

M. "physician" means an individual authorized to practice medicine or osteopathy;

N. "power of attorney for health care" means the designation of an agent to make health-care decisions for the individual granting the power, made while the individual has capacity;

O. "primary care practitioner" means a health-care practitioner designated by an individual or the individual's agent, guardian or surrogate to have primary responsibility for the individual's health care;

P. "principal" means an adult or emancipated minor who, while having capacity, has made a power of attorney for health care by which the adult or emancipated minor delegates the right to make health-care decisions for the adult or emancipated minor to an agent;

Q. "protected person" means an adult or emancipated minor for whom a guardian has been appointed;

R. "qualified health-care professional" means a health-care practitioner who is a physician, physician assistant, nurse practitioner, nurse, psychologist or social worker;

S. "reasonably available" means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health-care needs;

T. "state" means a state of the United States, the District of Columbia, the commonwealth of Puerto Rico or a territory or insular possession subject to the jurisdiction of the United States;

U. "supervising health-care practitioner" means the primary care practitioner, or if there is no primary care practitioner or if the primary care practitioner is not reasonably available, the health-care practitioner who has undertaken primary responsibility for an individual's health care; and

V. "surrogate" means an individual, other than a patient's agent or guardian, authorized under the Uniform Health-Care Decisions Act to make a health-care decision for the patient.

History: Laws 1995, ch. 182, § 1; 1997, ch. 168, § 1; 2009, ch. 159, § 1; 2015, ch. 116, § 4.

24-7A-2. Advance health-care directives.

A. An adult or emancipated minor, while having capacity, has the right to make his or her own health-care decisions and may give an individual instruction. The instruction may be oral or written; if oral, it must be made by personally informing a health-care provider. The instruction may be limited to take effect only if a specified condition arises.

B. An adult or emancipated minor, while having capacity, may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity under the Uniform Health-Care Decisions Act or Article 5 of the Uniform Probate Code [Chapter 45, Article 5 NMSA 1978]. The power may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an owner, operator or employee of a health-care institution at which the principal is receiving care.

C. Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

D. Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent, shall be

made according to the provisions of Section 11 [24-7A-11 NMSA 1978] of the Uniform Health-Care Decisions Act.

E. An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

F. A health-care decision made by an agent for a principal is effective without judicial approval.

G. A written advance health-care directive may include the individual's nomination of a guardian of the person.

History: Laws 1995, ch. 182, § 2.

24-7A-2.1. Prohibited practice.

A. No insurer or other provider of benefits regulated by the New Mexico Insurance Code [Chapter 59A NMSA 1978, except for Articles 30A and 42A] or a state agency shall require a person to execute or revoke an advance health-care directive as a condition for membership in, being insured for or receiving coverage or benefits under an insurance contract or plan.

B. No insurer may condition the sale, procurement or issuance of a policy, plan, contract, certificate or other evidence of coverage, or entry into a pension, profit-sharing, retirement, employment or similar benefit plan, upon the execution or revocation of an advance health-care directive; nor shall the existence of an advance health-care directive modify the terms of an existing policy, plan, contract, certificate or other evidence of coverage of insurance.

C. The provisions of this section shall be enforced by the superintendent of insurance under the New Mexico Insurance Code.

History: Laws 1997, ch. 168, § 14.

24-7A-3. Revocation of advance health-care directive.

A. An individual, while having capacity, may revoke the designation of an agent either by a signed writing or by personally informing the supervising health-care provider. If the individual cannot sign, a written revocation must be signed for the individual and be witnessed by two witnesses, each of whom has signed at the direction and in the presence of the individual and of each other.

B. An individual, while having capacity, may revoke all or part of an advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

C. A health-care provider, agent, guardian or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

D. The filing of a petition for or a decree of annulment, divorce, dissolution of marriage or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care. A designation revoked solely by this subsection is revived by the individual's remarriage to the former spouse, by a nullification of the divorce, annulment or legal separation or by the dismissal or withdrawal, with the individual's consent, of a petition seeking annulment, divorce, dissolution of marriage or legal separation.

E. An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict.

History: Laws 1995, ch. 182, § 3; 1997, ch. 168, § 2.

24-7A-4. Optional form.

The following form may, but need not, be used to create an advance health-care directive. The other sections of the Uniform Health-Care Decisions Act govern the effect of this or any other writing used to create an advance health-care directive. An individual may complete or modify all or any part of the following form:

"OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary care practitioner.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an

alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

(b) select or discharge health-care practitioners and institutions;

(c) approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and

(d) direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a primary care practitioner to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care practitioners you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

* *

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

_____
_____

(name of individual you choose as agent)

_____
_____

(address) (city) (state) (zip code)

_____
_____

(home phone) (work phone)

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

_____
_____

(name of individual you choose as first alternate agent)

_____
_____

(address) (city) (state) (zip code)

_____
_____

(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____
_____

(name of individual you choose as second alternate agent)

_____
_____

(address) (city) (state) (zip code)

_____
_____

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

_____
_____

_____
_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary care practitioner and one other qualified health-care professional determine that I am unable to make my own health-care decisions. If I initial this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in PART 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health-care practitioners and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

[ ] I CHOOSE NOT To Prolong Life

I do not want my life to be prolonged.

[ ] I CHOOSE To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

[ ] I CHOOSE To Let My Agent Decide

My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[ ] I DO NOT want artificial nutrition OR

[ ] I DO want artificial nutrition.

[ ] I DO NOT want artificial hydration unless required for my comfort OR

[ ] I DO want artificial hydration.

(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

_____
_____

_____
_____

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[ ] I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[ ] I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

_____
_____

_____
_____

[ ] I REFUSE to make an anatomical gift of any of my organs or tissue.

[ ] I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____
_____

_____
_____

(Add additional sheets if needed.)

PART 3

PRIMARY CARE PRACTITIONER

(11) I designate the following as my primary care practitioner:

_____
_____

(name of primary care practitioner)

_____
_____

(address) (city) (state) (zip code)

_____
_____

(phone)

If the primary care practitioner I have designated above is not willing, able or reasonably available to act as my primary care practitioner, I designate the following as my primary care practitioner:

_____
_____

(name of primary care practitioner)

_____
_____

(address) (city) (state) (zip code)

_____
_____

(phone)

* * * * * * * * * * * * * * * * * * * *

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care practitioner and any health-care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health-care practitioner.

(14) SIGNATURES: Sign and date the form here:

_____ _____
___ ___

(date) (sign your name)

_____	_____
(address)	(print your name)
_____	_____
(city) (state)	(your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness	Second witness
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city) (state)	(city) (state)
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(date)	(date)".

History: Laws 1995, ch. 182, § 4; 1997, ch. 168, § 3; 2000, ch. 54, § 9; 2015, ch. 116, § 5.

24-7A-5. Decisions by surrogate.

A. A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined according to the provisions of Section 24-7A-11 NMSA 1978 to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

B. An adult or emancipated minor, while having capacity, may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated or unless there is a pending petition for annulment, divorce, dissolution of marriage or legal separation;

(2) an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being;

(3) an adult child;

(4) a parent;

(5) an adult brother or sister; or

(6) a grandparent.

C. If none of the individuals eligible to act as surrogate under Subsection B of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values and who is reasonably available may act as surrogate.

D. A surrogate shall communicate his assumption of authority as promptly as practicable to the patient, to members of the patient's family specified in Subsection B of this section who can be readily contacted and to the supervising health-care provider.

E. If more than one member of a class assumes authority to act as surrogate and they do not agree on a health-care decision and the supervising health-care provider is so informed, the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health-care decision and the supervising health-care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.

F. A surrogate shall make a health-care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

G. A health-care decision made by a surrogate for a patient shall not be made solely on the basis of the patient's pre-existing physical or medical condition or pre-existing or projected disability.

H. A health-care decision made by a surrogate for a patient is effective without judicial approval.

I. A patient, at any time, may disqualify any person, including a member of the patient's family, from acting as the patient's surrogate by a signed writing or by

personally informing a health-care provider of the disqualification. A health-care provider who is informed by the patient of a disqualification shall promptly communicate the fact of disqualification to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

J. Unless related to the patient by blood, marriage or adoption, a surrogate may not be an owner, operator or employee of a health-care institution at which the patient is receiving care.

K. A supervising health-care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

History: Laws 1995, ch. 182, § 5; 1997, ch. 168, § 4.

24-7A-6. Decisions by guardian.

A. A guardian shall comply with the protected person's individual instructions made while the protected person had capacity and shall not disregard the protected person's preferences contained in an advance health-care directive unless the appointing court expressly so authorizes after notice to the agent, if any, and the protected person. The court may disregard such preferences if it finds by clear and convincing evidence that the preferences do not accurately reflect the free choice of the protected person at the time of making the individual instructions or that the protected person revoked the individual instructions while the protected person had capacity pursuant to Subsection B of Section 24-7A-3 NMSA 1978. This provision does not affect the court's ability to grant relief pursuant to a petition as provided in Section 24-7A-14 NMSA 1978.

B. A health-care decision of an agent appointed by a person having capacity takes precedence over that of a guardian, unless the appointing court expressly directs otherwise after notice to the agent and the protected person.

C. Subject to the provisions of Subsections A and B of this section, a health-care decision made by a guardian for the protected person is effective without judicial approval, if the appointing court has expressly authorized the guardian to make health-care decisions for the protected person, in accordance with the provisions of Section 45-5-312 NMSA 1978, after notice to the protected person and any agent.

History: Laws 1995, ch. 182, § 6; 2009, ch. 159, § 2.

24-7A-6.1. Life-sustaining treatment for unemancipated minors.

A. Except as otherwise provided by law, a parent or guardian of an unemancipated minor may make that minor's health-care decisions.

B. A parent or guardian of an unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment for the unemancipated minor, subject to the provisions of this section and the standards for surrogate decision-making for adults provided for in the Uniform Health-Care Decisions Act.

C. Subject to the provisions of Subsection B of this section, if an unemancipated minor has capacity sufficient to understand the nature of that unemancipated minor's medical condition, the risks and benefits of treatment and the contemplated decision to withhold or withdraw life-sustaining treatment, that unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment.

D. For purposes of Subsection C of this section, a determination of the mental and emotional capacity of an unemancipated minor shall be determined by two qualified health-care professionals, one of whom shall be the unemancipated minor's primary care practitioner and the other of whom shall be a health-care practitioner that works with unemancipated minors of the minor's age in the ordinary course of that health-care practitioner's practice. If the unemancipated minor lacks capacity due to mental illness or developmental disability, one of the qualified health-care professionals shall be a person whose training and expertise aid in the assessment of functional impairment.

E. If the unemancipated minor's primary care practitioner has reason to believe that a parent or guardian of an unemancipated minor, including a non-custodial parent, has not been informed of a decision to withhold or withdraw life-sustaining treatment, the primary care practitioner shall make reasonable efforts to determine if the uninformed parent or guardian has maintained substantial and continuous contact with the unemancipated minor and, if so, shall make reasonable efforts to notify that parent or guardian before implementing a decision.

F. If there is disagreement regarding the decision to withhold or withdraw life-sustaining treatment for an unemancipated minor, the provisions of Section 24-7A-11 NMSA 1978 shall apply.

History: Laws 1997, ch. 168, § 13; 2009, ch. 220, § 2; 2015, ch. 116, § 6.

24-7A-6.2. Consent to health care for certain minors fourteen years of age or older.

A. An unemancipated minor fourteen years of age or older who has capacity to consent may give consent for medically necessary health care; provided that the minor is:

(1) living apart from the minor's parents or legal guardian; or

(2) the parent of a child.

B. For purposes of this section, "medically necessary health care" means clinical and rehabilitative, physical, mental or behavioral health services that are:

(1) essential to prevent, diagnose or treat medical conditions or that are essential to enable an unemancipated minor to attain, maintain or regain functional capacity;

(2) delivered in the amount and setting with the duration and scope that is clinically appropriate to the specific physical, mental and behavioral health-care needs of the minor;

(3) provided within professionally accepted standards of practice and national guidelines; and

(4) required to meet the physical, mental and behavioral health needs of the minor, but not primarily required for convenience of the minor, health-care provider or payer.

C. The consent of the unemancipated minor to examination or treatment pursuant to this section shall not be disaffirmed because of minority.

D. The parent or legal guardian of an unemancipated minor who receives medically necessary health care is not liable for payment for those services unless the parent or legal guardian has consented to such medically necessary health care; provided that the provisions of this subsection do not relieve a parent or legal guardian of liability for payment for emergency health care provided to an unemancipated minor.

E. A health-care provider or a health-care institution shall not be liable for reasonably relying on statements made by an unemancipated minor that the minor is eligible to give consent pursuant to Subsection A of this section.

F. Nothing in this section shall otherwise limit the rights of an unemancipated minor to consent to treatment, nor shall this section be read to conflict with the rights of parents and children pursuant to the Children's Mental Health and Developmental Disabilities Act [32A-6A-1 to 32A-6A-30 NMSA 1978].

History: 1978 Comp., § 24-7A-6.2, as enacted by Laws 2009, ch. 220, § 3.

24-7A-7. Obligations of health-care practitioner.

A. Before implementing a health-care decision made for a patient, a supervising health-care practitioner shall promptly communicate to the patient the decision made and the identity of the person making the decision.

B. A supervising health-care practitioner who knows of the existence of an advance health-care directive, a revocation of an advance health-care directive, a challenge to a

determination of lack of capacity or a designation or disqualification of a surrogate shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and, if one is furnished, shall arrange for its maintenance in the health-care record.

C. A supervising health-care practitioner who makes or is informed of a determination that a patient lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent, guardian or surrogate shall promptly record the determination in the patient's health-care record and communicate the determination to the patient and to any person then authorized to make health-care decisions for the patient.

D. Except as provided in Subsections E and F of this section, a health-care practitioner or health-care institution providing care to a patient shall comply:

(1) before and after the patient is determined to lack capacity, with an individual instruction of the patient made while the patient had capacity;

(2) with a reasonable interpretation of the individual instruction made by a person then authorized to make health-care decisions for the patient; and

(3) with a health-care decision for the patient that is not contrary to an individual instruction of the patient and is made by a person then authorized to make health-care decisions for the patient, to the same extent as if the decision had been made by the patient while having capacity.

E. A health-care practitioner may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the health-care institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.

F. A health-care practitioner or health-care institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care practitioner or health-care institution. "Medically ineffective health care" means treatment that would not offer the patient any significant benefit, as determined by a health-care practitioner.

G. A health-care practitioner or health-care institution that declines to comply with an individual instruction or health-care decision shall:

(1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(2) provide continuing care to the patient until a transfer can be effected; and

(3) unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care practitioner or health-care institution that is willing to comply with the individual instruction or decision.

H. A health-care practitioner or health-care institution may not require or prohibit the execution or revocation of an advance health-care directive as a condition for providing health care.

I. The Uniform Health-Care Decisions Act does not require or permit a health-care institution or health-care practitioner to provide any type of health care for which the health-care institution or health-care practitioner is not licensed, certified or otherwise authorized or permitted by law to provide.

History: Laws 1995, ch. 182, § 7; 1997, ch. 168, § 5; 2015, ch. 116, § 7.

24-7A-8. Health-care information.

Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request, receive, examine, copy and consent to the disclosure of medical or any other health-care information.

History: Laws 1995, ch. 182, § 8.

24-7A-9. Immunities.

A. A health-care provider or health-care institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health-care provider or health-care institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying or attempting to comply with a health-care decision of a person apparently having authority to make a health-care decision for a patient, including a decision to withhold or withdraw health care or make an anatomical gift;

(2) declining to comply with a health-care decision of a person based on a belief that the person then lacked authority;

(3) complying or attempting to comply with an advance health-care directive and assuming that the directive was valid when made and has not been revoked or terminated;

(4) declining to comply with a health-care directive as permitted by Subsection E or F of Section 24-7A-7 NMSA 1978; or

(5) complying or attempting to comply with any other provision of the Uniform Health-Care Decisions Act.

B. An individual acting as agent, guardian or surrogate under the Uniform Health-Care Decisions Act is not subject to civil or criminal liability or to discipline for unprofessional conduct for health-care decisions made in good faith.

History: Laws 1995, ch. 182, § 9; 2000, ch. 54, § 10.

24-7A-10. Statutory damages.

A. A health-care provider or health-care institution that intentionally violates the Uniform Health-Care Decisions Act is subject to liability to the aggrieved individual for damages of five thousand dollars ($5,000) or actual damages resulting from the violation, whichever is greater, plus reasonable attorney fees.

B. A person who intentionally falsifies, forges, conceals, defaces or obliterates an individual's advance health-care directive or a revocation of an advance health-care directive without the individual's consent or a person who coerces or fraudulently induces an individual to give, revoke or not give or revoke an advance health-care directive is subject to liability to that individual for damages of five thousand dollars ($5,000) or actual damages resulting from the action, whichever is greater, plus reasonable attorney fees.

C. The damages provided in this section are in addition to other types of relief available under other law, including civil and criminal law and law providing for disciplinary procedures.

History: Laws 1995, ch. 182, § 10; 1997, ch. 168, § 6.

24-7A-11. Capacity.

A. The Uniform Health-Care Decisions Act does not affect the right of an individual to make health-care decisions while having capacity to do so.

B. An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive and to designate a surrogate.

C. Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent shall be made by two qualified health-care professionals, one of whom shall be the primary care practitioner. If the lack of capacity is determined to exist because of mental illness or

developmental disability, one of the qualified health-care professionals shall be a person whose training and expertise aid in the assessment of functional impairment.

D. An individual shall not be determined to lack capacity solely on the basis that the individual chooses not to accept the treatment recommended by a health-care practitioner.

E. An individual, at any time, may challenge a determination that the individual lacks capacity by a signed writing or by personally informing a health-care practitioner of the challenge. A health-care practitioner who is informed by the individual of a challenge shall promptly communicate the fact of the challenge to the supervising health-care practitioner and to any health-care institution at which the individual is receiving care. Such a challenge shall prevail unless otherwise ordered by the court in a proceeding brought pursuant to the provisions of Section 24-7A-14 NMSA 1978.

F. A determination of lack of capacity under the Uniform Health-Care Decisions Act shall not be evidence of incapacity under the provisions of Article 5 of the Uniform Probate Code [Chapter 45 NMSA 1978].

History: Laws 1995, ch. 182, § 11; 1997, ch. 168, § 7; 2015, ch. 116, § 8.

24-7A-12. Effect of copy.

A copy of a written advance health-care directive, revocation of an advance health-care directive or designation or disqualification of a surrogate has the same effect as the original.

History: Laws 1995, ch. 182, § 12.

24-7A-13. Effect of the Uniform Health-Care Decisions Act.

A. The Uniform Health-Care Decisions Act does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health-care directive.

B. Death resulting from the withholding or withdrawal of health care in accordance with the Uniform Health-Care Decisions Act does not for any purpose:

(1) constitute a suicide, a homicide or other crime; or

(2) legally impair or invalidate a governing instrument, notwithstanding any term of the governing instrument to the contrary. "Governing instrument" means a deed, will, trust, insurance or annuity policy, account with POD (payment on death designation), security registered in beneficiary form (TOD), pension, profit-sharing, retirement, employment or similar benefit plan, instrument creating or exercising a

power of appointment or a dispositive, appointive or nominative instrument of any similar type.

C. The Uniform Health-Care Decisions Act does not authorize mercy killing, assisted suicide, euthanasia or the provision, withholding or withdrawal of health care, to the extent prohibited by other statutes of this state.

D. The Uniform Health-Care Decisions Act does not authorize or require a health-care provider or health-care institution to provide health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution.

E. The Uniform Health-Care Decisions Act does not authorize an agent or surrogate to consent to the admission of an individual to a mental health-care facility. If the individual's written advance health-care directive expressly permits treatment in a mental health-care facility, the agent or surrogate may present the individual to a facility for evaluation for admission.

F. The Uniform Health-Care Decisions Act does not affect other statutes of this state governing treatment for mental illness of an individual admitted to a mental health-care institution.

History: Laws 1995, ch. 182, § 13; 1997, ch. 168, § 8.

24-7A-14. Judicial relief.

On petition of a patient, the patient's agent, guardian or surrogate, a health-care provider or health-care institution involved with the patient's care, an individual described in Subsection B or C of Section 24-7A-5 NMSA 1978, the district court may enjoin or direct a health-care decision or order other equitable relief. A proceeding under this section is governed by the Rules of Civil Procedure for the District Courts.

History: Laws 1995, ch. 182, § 14; 1997, ch. 168, § 9.

24-7A-15. Uniformity of application and construction.

The Uniform Health-Care Decisions Act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject matter of that act among states enacting it.

History: Laws 1995, ch. 182, § 15.

24-7A-16. Transitional provisions.

A. An advance health-care directive is valid for purposes of the Uniform Health-Care Decisions Act if it complies with the provisions of that act, regardless of when or where executed or communicated.

B. The Uniform Health-Care Decisions Act does not impair a guardianship, living will, durable power of attorney, right-to-die statement or declaration or other advance directive for health-care decisions that is in effect before July 1, 1995.

C. Any advance directive, durable power of attorney for heath care decisions, living will, right-to-die statement or declaration or similar document that is executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction shall be deemed valid and enforceable in this state to the same extent as if it were properly made in this state.

History: Laws 1995, ch. 182, § 16; 1997, ch. 168, § 10.

24-7A-17. Short title.

Chapter 24, Article 7A NMSA 1978 may be cited as the "Uniform Health-Care Decisions Act".

History: Laws 1995, ch. 182, § 17; 2009, ch. 159, § 3; 2009, ch. 220, § 1.

24-7A-18. Severability.

If any provision of the Uniform Health-Care Decisions Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of that act which can be given effect without the invalid provision or application, and to this end the provisions of that act are severable.

History: Laws 1995, ch. 182, § 18.

ARTICLE 7B
Mental Health Care Treatment Decisions

24-7B-1. Short title.

Chapter 24, Article 7B NMSA 1978 may be cited as the "Mental Health Care Treatment Decisions Act".

History: Laws 2006, ch. 7, § 1; 2009, ch. 159, § 4.

24-7B-2. Purpose.

The purpose of the Mental Health Care Treatment Decisions Act is to ensure appropriate care and treatment of persons with behavioral health needs in the community.

History: Laws 2006, ch. 7, § 2.

24-7B-3. Definitions.

As used in the Mental Health Care Treatment Decisions Act:

A. "advance directive for mental health treatment" means an individual instruction or power of attorney for mental health treatment made pursuant to the Mental Health Care Treatment Decisions Act;

B. "agent" means an individual designated in a power of attorney for mental health treatment to make a mental health treatment decision for the individual granting the power;

C. "capacity" means an individual's ability to understand and appreciate the nature and consequences of proposed mental health treatment, including significant benefits and risks and alternatives to the proposed mental health treatment, and to make and communicate an informed mental health treatment decision. A written determination or certification of lack of capacity shall be made only according to the provisions of the Mental Health Care Treatment Decisions Act;

D. "emancipated minor" means an individual between the ages of sixteen and eighteen who has been married, who is on active duty in the armed forces or who has been declared by court order to be emancipated;

E. "guardian" means a judicially appointed guardian having authority to make a mental health decision for an individual;

F. "individual instruction" means an individual's direction concerning a mental health treatment decision for the individual, made while the individual has capacity, which is to be implemented when the individual has been determined to lack capacity;

G. "mental health treatment" means services provided for the prevention of, amelioration of symptoms of or recovery from mental illness or emotional disturbance, including electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or evaluation for admission to a facility for care or treatment of persons with mental illness, if required;

H. "mental health treatment decision" means a decision made by an individual or the individual's agent or guardian regarding the individual's mental health treatment, including:

(1) selection and discharge of health care or mental health treatment providers and institutions;

(2) approval or disapproval of diagnostic tests, programs of medication and mental health treatment; and

(3) directions relating to mental health treatment;

I. "mental health treatment facility" means an institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide mental health treatment in the ordinary course of business;

J. "mental health treatment provider" or "health care provider" means an individual licensed, certified or otherwise authorized or permitted by law to provide diagnosis or mental health treatment in the ordinary course of business or practice of a profession;

K. "mental illness" means a substantial disorder of a person's emotional process, thoughts or cognition that grossly impairs judgment, behavior or capacity to recognize reality, but "mental illness" does not mean a developmental disability;

L. "power of attorney for mental health treatment" means the designation of an agent to make mental health treatment decisions for the individual granting the power, made while the individual has capacity;

M. "primary health care professional" means a qualified health care professional designated by an individual or the individual's agent or guardian to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated qualified health care professional is not reasonably available, a qualified health care professional who undertakes that responsibility;

N. "principal" means an adult or emancipated minor who, while having capacity, has made a power of attorney for mental health treatment by which the adult or emancipated minor delegates the right to make mental health treatment decisions for that adult or emancipated minor to an agent;

O. "protected person" means an adult or emancipated minor for whom a guardian has been appointed;

P. "qualified health care professional" means a licensed health care provider who is a physician, physician assistant, nurse practitioner, nurse or psychologist;

Q. "reasonably available" means able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's mental health treatment needs; and

R. "supervising health care provider" means the primary qualified health care professional or, if the primary qualified health care professional is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

History: Laws 2006, ch. 7, § 3; 2009, ch. 159, § 5.

24-7B-4. Advance directive for mental health treatment.

A. An adult or emancipated minor, while having capacity, has the right to make the adult or emancipated minor's own mental health treatment decisions and may give an individual instruction. The individual instruction may be oral or written; if oral, it shall be made by personally informing a health care provider. The individual instruction may be limited to take effect only if a specified condition arises.

B. An adult or emancipated minor, while having capacity, may execute a power of attorney for mental health treatment that may authorize the agent to make any mental health treatment decision the principal could have made while having capacity. The power of attorney for mental health treatment shall be in writing signed by the principal and witnessed pursuant to Subsections I and J of this section. The power of attorney for mental health treatment shall remain in effect notwithstanding the principal's later incapacity under the Mental Health Care Treatment Decisions Act or Article 5 of the Uniform Probate Code [45-5-101 NMSA 1978]. The power of attorney for mental health treatment may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an attending qualified health care professional or an employee of the qualified health care professional or an owner, operator or employee of a mental health treatment facility at which the principal is receiving care.

C. Unless otherwise specified in a power of attorney for mental health treatment, the authority of an agent becomes effective only upon certification that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

D. Unless otherwise specified in a written advance directive for mental health treatment, written certification that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent shall be made according to the provisions of the Mental Health Care Treatment Decisions Act.

E. An agent shall make a mental health treatment decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

F. A mental health treatment decision made by an agent for a principal is effective without judicial approval.

G. A written advance directive for mental health treatment may include the individual's nomination of a choice of guardian of the individual.

H. The fact that an individual has executed an advance directive for mental health treatment shall not constitute an indication of mental illness.

I. A written advance directive for mental health treatment is valid only if it is signed by the principal and a witness who is at least eighteen years of age and who attests that the principal:

(1) is known to the witness;

(2) signed the advance directive for mental health treatment in the witness' presence;

(3) appears to have capacity; and

(4) is not acting under duress, fraud or undue influence.

J. For purposes of the advance directive for mental health treatment, the witness shall not be:

(1) an agent of the principal;

(2) related to the principal by blood or marriage;

(3) entitled to any part of the principal's estate or have a claim against the principal's estate;

(4) the attending qualified health care professional; or

(5) an owner, operator or employee of a mental health treatment facility at which the principal is receiving care or of any parent organization of the mental health treatment facility.

History: Laws 2006, ch. 7, § 4.

24-7B-5. Capacity.

A. The Mental Health Care Treatment Decisions Act does not affect the right of an individual to make mental health treatment decisions while having the capacity to do so.

B. An individual is presumed to have capacity to make a mental health treatment decision, to give an advance directive for mental health treatment or to revoke an advance directive for mental health treatment.

C. An individual shall not be determined to lack capacity solely on the basis that the individual chooses not to accept the treatment recommended by a health care provider.

D. An individual, at any time, may challenge a determination that the individual lacks capacity by a signed writing or by personally informing a health care provider of the challenge. A health care provider who is informed by the individual of a challenge shall promptly communicate the fact of the challenge to the supervising health care provider and to any mental health treatment facility at which the individual is receiving care. Such a challenge shall prevail unless the agent or the treating mental health care provider obtains an order in district court finding the principal does not have the capacity to make mental health treatment decisions.

E. A determination of lack of capacity under the Mental Health Care Treatment Decisions Act shall not be evidence of incapacity under the provisions of Article 5 of the Uniform Probate Code [45-5-101 NMSA 1978].

F. A determination of incapacity shall only be made by two persons, a qualified health care professional and a mental health treatment provider. If after the examination the principal is determined to lack capacity and is in need of mental health treatment, a written certification, substantially in the form provided in Subsection G of this section, of the principal's condition shall be made a part of the principal's medical record.

G. The following certification of the examination of a principal determining whether the principal is in need of mental health treatment and whether the principal does or does not lack capacity may be used by examiners:

"OPTIONAL EXAMINER'S CERTIFICATION

We, the undersigned, have made an examination of _____, and do hereby certify that we have made a careful personal examination of the actual condition of the person and on such examination we find that _____:

1. (Is) (Is not) in need of mental health treatment; and

2. (Does) (Does not) lack capacity to participate in decisions about (her) (his) mental health treatment.

The facts and circumstances on which we base our opinions are stated in the following report of symptoms and history of case, which is hereby made a part hereof.

According to the advance directive for mental health treatment, (name of patient) _____, wishes to receive mental health treatment in accordance

with the preferences and instructions stated in the advance directive for mental health treatment.

We are duly licensed to practice in this state of New Mexico, are not related to _____ by blood or marriage and have no interest in her/his estate.

Witness our hands this _____ day of _____, 20___

_____ M.D., D.O., Ph.D., Other

_____ M.D., D.O., Ph.D., Other

Subscribed and sworn to

before me this _____ day of _____, 20____

_____

Notary Public

REPORT OF SYMPTOMS AND HISTORY OF CASE BY EXAMINERS

I. GENERAL

Complete name _____

Place of residence _____

Sex _____ Ethnicity _____

Age _____

Date of Birth _____

II. STATEMENT OF FACTS AND CIRCUMSTANCES

Our determination that the principal (is) (is not) in need for mental health treatment is based on the following:

_____
_____

_____
_____

Our determination that the principal does not have the capacity to participate in the principal's mental health treatment decisions is based on:

1. the principal's ability to understand and communicate the nature of the proposed health care or mental health treatment described as:

_____
_____

_____
_____

2. the principal's ability to understand and communicate the consequences of the proposed health care or mental health treatment described as:

_____
_____

_____
_____

3. the principal's ability to understand and communicate the significant benefits, risks and alternatives to the proposed health care or mental health treatment described as:

_____
_____

_____
_____

4. the principal's ability to understand and communicate a choice about the proposed health care or mental health treatment described as:

_____
_____

_____
_____

III. NAME AND RELATIONSHIPS OF FAMILY MEMBERS/OTHERS TO BE NOTIFIED

Other data _____

Dated at _____, New Mexico, this _____ day

of _____, 20____

_____ M.D., D.O., Ph.D.,

_____ Other Address

_____ M.D., D.O., Ph.D.,

_____ Other Address."

History: Laws 2006, ch. 7, § 5.

24-7B-6. Revocation of advance directive for mental health treatment.

A. An individual, while having capacity, may revoke the designation of an agent either by a signed writing or by personally informing the supervising health care provider. If the individual cannot sign, a written revocation shall be signed for the individual and be witnessed by two witnesses pursuant to Subsections I and J of Section 4 [24-7B-4 NMSA 1978] of the Mental Health Care Treatment Decisions Act, each of whom has signed at the direction of the individual and in the presence of the individual and each other.

B. An individual, while having capacity, may revoke all or part of an advance directive for mental health treatment, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

C. A mental health treatment provider, agent or guardian who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health care provider and to any mental health treatment facility at which the patient is receiving care.

D. The filing of a petition for or a decree of annulment, divorce, dissolution of marriage or legal separation revokes a previous designation of a spouse as agent, unless otherwise specified in the decree or in a power of attorney for mental health treatment. A designation revoked solely by this subsection is revived by the individual's remarriage to the former spouse, by a nullification of the divorce, annulment or legal separation or by the dismissal or withdrawal, with the individual's consent, of a petition seeking annulment, divorce, dissolution of marriage or legal separation.

E. An advance directive for mental health treatment that conflicts with an earlier advance directive for mental health treatment revokes the earlier directive to the extent of the conflict.

F. Unless otherwise specified in the power of attorney for mental health treatment, an advance health-care directive pursuant to the Uniform Health-Care Decisions Act

[Chapter 24, Article 7A NMSA 1978] and an advance directive for mental health treatment shall be treated separately. A revocation of a power of attorney for mental health treatment shall not affect the validity of a power of attorney.

History: Laws 2006, ch. 7, § 6.

24-7B-7. Optional form for advance directive for mental health treatment.

A. The form provided in Subsection E of this section may be used to create an individual instruction regarding mental health treatment. An individual may complete or modify all or any part of the form. The Mental Health Care Treatment Decisions Act governs the effect of this or any other writing used to create an advance directive for mental health treatment.

B. A principal may designate a capable person eighteen years of age or older to act as an agent to make mental health treatment decisions. An alternative agent may also be designated to act as an agent if the original agent is unable or unwilling to act at any time. An appointment of an agent may be accomplished by using the form provided by Subsection E of this section.

C. An agent who has accepted the appointment in writing shall have authority to make decisions, in consultation with the primary health care professional, about mental health treatment on behalf of the principal only when the principal is certified to lack capacity and to require mental health treatment as provided by the Mental Health Care Treatment Decisions Act. These decisions shall be consistent with any wishes or instructions the principal has expressed in the instruction. If the wishes or instructions of the principal are not expressed, the agent shall act in what the agent believes to be the best interest of the principal. The agent may consent to evaluation for admission to inpatient mental health treatment on behalf of the principal if so authorized in the advance directive for mental health treatment.

D. An agent may renounce the agent's authority by giving notice to the principal. If a principal lacks capacity, the agent may renounce the agent's authority by giving notice to the named alternative agent, if any, or, if none, to the attending qualified health care professional or health care provider. The primary health care professional or health care provider shall note the withdrawal of the last named agent as part of the principal's medical record.

E. An advance directive for mental health treatment may be executed by using the following optional form, completed or modified to the extent desired by the individual, and the form may be notarized:

"ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I, _____, being a person with capacity, willfully and voluntarily make known my wishes about mental health treatment, by my instructions to others through my advance directive for mental health treatment, or by my appointment of an agent, or both. If a guardian or an agent is appointed to make mental health decisions for me, I intend this document to take precedence over other means of ascertaining my wishes and interests.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. I intend this directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if one qualified health care professional and one mental health treatment provider find that I am an incapacitated person, unless I successfully challenge the determination of incapacity.

I understand there are some circumstances where my provider may not have to follow my directive, specifically, if the treatment requested in this directive is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable law.

I thus do hereby declare:

I. DECLARATION FOR MENTAL HEALTH TREATMENT

If a mental health treatment provider and a qualified health care professional, one of whom is my primary health care professional, if reasonably available, determine that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my primary health care professional and a mental health treatment provider, pursuant to the Mental Health Care Treatment Decisions Act, to provide the mental health treatment I have indicated below by my signature.

I understand that "mental health treatment" means services provided for the prevention of, amelioration of symptoms of or recovery from mental illness or emotional disturbance, including but not limited to electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or evaluation for admission to a facility for care or treatment of persons with mental illness, if required.

Preferences and Instructions About Treatment, Facilities and Physicians

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____ Contact information _____

Dr. _____ Contact information _____

I do not wish to be treated by Dr. _____

Other Preferences: _____

Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name: _____ Profession: _____

Contact Information _____

Name: _____ Profession: _____

Contact Information _____

Preferences and Instructions About Medications for Mental Health Treatment

(*initial and complete all that apply*)

____ I consent, and authorize my agent to consent, to the following medications:

_____
_____

____ I do not consent, and I do not authorize my agent to consent, to the administration of the following medications:

_____
_____

____ I am willing to take the medications excluded above if my only reason for excluding them is the side effects, which include _____, and these side effects can be eliminated by dosage adjustment or other means.

____ I am willing to try any other medications the hospital doctor recommends.

____ I am willing to try any other medications my outpatient doctor recommends.

____ I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:

_____
_____

I have the following other preferences or instructions about medications:

_____
_____

Preferences and Instructions About Hospitalization and Alternatives

(*initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on*)

____ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalization.

____ I would also like the interventions below to be tried before hospitalization is considered:

____ Calling someone or having someone call me when needed

Name: _____ Telephone: _____

____ Having a mental health service provider come to see me

____ Going to a crisis triage center or emergency room

____ Staying overnight at a crisis respite (temporary) bed

____ Seeing a provider for help with psychiatric medications

____ Other, specify: _____

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent to consent, to evaluation for admission to inpatient mental health treatment.

(*Sign one*)

____ If deemed appropriate by my agent and treating physician

_____ Signature

or

____ Under the following circumstances (*specify symptoms, behaviors or circumstances that indicate the need for hospitalization*)

_____
_____

_____ Signature

____ I do not consent, or authorize my agent to consent, to evaluation for admission to inpatient treatment

_____ Signature

Preferences and Instructions About Use of Seclusion or Restraint

I would like the interventions below to be tried before use of seclusion or restraint is considered (*initial all that apply*)

____ "Talk me down": one-on-one

____ More medication

____ Time out/privacy

____ Show of authority/force

____ Shift my attention to something else

____ Set firm limits on my behavior

____ Help me to discuss/vent feelings

____ Decrease stimulation

____ Offer to have neutral person settle dispute

____ Other, specify _____

If it is determined that I am engaging in behavior that requires seclusion, physical restraint and/or emergency use of medication, I prefer these interventions in the order I have chosen (*choose "1" for first choice, "2" for second choice, and so on*):

____ Seclusion

____ Seclusion and physical restraint (combined)

____ Medication by injection

____ Medication in pill or liquid form

In the event my physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in this directive. The preferences and instructions I have expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

Preferences and Instructions About Electroconvulsive Therapy

My wishes regarding electroconvulsive therapy are (*sign one*):

____ I do not consent, nor authorize my agent to consent, to the administration of electroconvulsive therapy.

_____ Signature

____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy.

_____ Signature

____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

_____
_____

_____ Signature

Preferences and Instructions About Who Is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: _____

Name: _____

Name: _____

I understand that persons not listed above may be permitted to visit me.

Additional Instructions About My Mental Health Care

Other instructions about my mental health care: _____

In case of emergency, please contact: _____

Name: _____

Address: _____

Work Telephone: _____

Home telephone: _____

Physician: _____

Address: _____

Telephone: _____

The following may help me to avoid a hospitalization:

_____

I generally react to being hospitalized as follows:

_____

Staff of the hospital or crisis unit can help me by doing the following:

_____

Refusal of Treatment

I do not consent to any mental health treatment.

_____

Signature

I further state that this document and the information contained in it may be released to any requesting licensed mental health professional.

_____ _____

Signature of principal Date

_____ _____

Signature of witness Date

II. APPOINTMENT OF AGENT

If my primary health care professional and a mental health provider determine that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my primary health care professional and other health care providers, pursuant to the Mental Health Care Treatment Decisions Act, to follow the instructions of my agent.

I hereby appoint:

Name _____

Address _____

Telephone _____ to act as my agent to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to act as my agent:

Name _____

Address _____

Telephone _____

My agent is authorized to make decisions that are consistent with the wishes I have expressed in my declaration. If my wishes are not expressed, my agent is to act in what he or she believes to be my best interest.

_____ _____

Signature of principal Date

III. CONFLICTING PROVISION

I understand that if I have completed both a declaration and have appointed an agent and if there is a conflict between my agent's decision and my declaration, my declaration shall take precedence unless I indicate otherwise.

_____ Signature

I understand that if I have completed both an advance health care directive and an advance directive for mental health treatment, that those directives should be executed as separate instructions.

_____ Signature

IV. OTHER PROVISIONS

1. In the absence of my ability to give directions regarding my mental health treatment, it is my intention that this advance directive for mental health treatment shall be honored as the expression of my legal right to consent or to refuse to consent to mental health treatment.

2. I direct the following concerning the care of my minor children:

_____
_____

3. This advance directive for mental health treatment shall be in effect until it is revoked.

4. I understand that I may revoke this advance directive for mental health treatment at any time.

5. I understand and agree that if I have any prior advance directives for mental health treatment, and if I sign this advance directive for mental health treatment, my prior advance directives for mental health treatment are revoked.

6. I understand the full importance of this advance directive for mental health treatment and I am emotionally and mentally competent to make this advance directive for mental health treatment.

Signed this _____ day of _____, 20__

_____

Signature

_____

City, county and state of residence

This advance directive was signed in my presence.

_____

Signature of witness

_____

Address

_____."

History: Laws 2006, ch. 7, § 7.

24-7B-8. Decisions by guardian.

A. A guardian shall comply with the protected person's individual instructions made while the protected person had capacity and may not disregard the protected person's preferences contained in an advance directive for mental health treatment unless the appointing court expressly so authorizes after notice to the agent, if any, and the protected person. The court may disregard such preferences if it finds by clear and convincing evidence that the preferences do not accurately reflect the free choice of the protected person at the time of making the individual instructions or that the protected person revoked the individual instructions while the protected person had capacity pursuant to Subsection B of Section 24-7A-3 NMSA 1978.

B. A mental health treatment decision of an agent appointed by an individual having capacity takes precedence over that of a guardian, unless the appointing court expressly directs otherwise after notice to the agent and the protected person.

C. Subject to the provisions of Subsections A and B of this section, a mental health treatment decision made by a guardian for the protected person is effective without judicial approval, if the appointing court has expressly authorized the guardian to make mental health treatment decisions for the protected person, in accordance with the provisions of Sections 43-1-15 or 45-5-312 NMSA 1978, after notice to the protected person and any agent.

History: Laws 2006, ch. 7, § 8; 2009, ch. 159, § 6.

24-7B-9. Obligations of mental health treatment provider.

A. Before implementing a mental health treatment decision made for a patient, a supervising health care provider shall promptly communicate to the patient the decision made and the identity of the person making the decision.

B. A supervising health care provider who knows of the existence of an advance directive for mental health treatment, a revocation of an advance directive for mental health treatment or a challenge to a determination or certification of lack of capacity shall promptly record its existence in the patient's health care record and, if it is in writing, shall request a copy and, if one is furnished, shall arrange for its maintenance in the health care record.

C. A qualified health care professional shall disclose an advance directive for mental health treatment to other qualified health care professionals only when it is determined that disclosure is necessary to give effect to or provide treatment in accordance with an individual instruction.

D. A supervising health care provider who makes or is informed of a written determination or certification pursuant to Section 5 [24-7B-5 NMSA 1978] of the Mental Health Care Treatment Decisions Act that a patient lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent or guardian shall promptly record the determination in the patient's health care record and communicate the determination or certification to the patient and to any person then authorized to make mental health treatment decisions for the patient.

E. Except as provided in Subsections F and G of this section, a health care provider or mental health treatment facility providing care to a patient shall comply:

(1) before and after the patient is determined to lack capacity, with an individual instruction of the patient made while the patient had capacity;

(2) with a reasonable interpretation of the individual instruction made by a person then authorized to make mental health treatment decisions for the patient; and

(3) with a mental health treatment decision for the patient that is not contrary to an individual instruction of the patient and is made by a person then authorized to make mental health treatment decisions for the patient, to the same extent as if the decision had been made by the patient while having capacity.

F. A mental health treatment provider may only decline to comply with an individual instruction or mental health treatment decision for any of the following reasons:

(1) the treatment requested is infeasible or unavailable;

(2) the facility or provider is not licensed or authorized to provide the treatment requested; or

(3) the treatment requested conflicts with other applicable law.

G. A mental health treatment provider or mental health treatment facility may decline to comply with an individual instruction or mental health treatment decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the mental health treatment provider or mental health treatment facility. "Medically ineffective health care" means treatment that would not offer the patient any significant benefit, as determined by a physician chosen by the principal or agent.

H. A health care provider or mental health treatment facility that declines to comply with an individual instruction or mental health care decision shall:

(1) promptly so inform the patient, if possible, and any person then authorized to make mental health care decisions for the patient;

(2) provide continuing care to the patient until a transfer can be effected; and

(3) unless the patient or person then authorized to make mental health treatment decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or mental health treatment facility that is willing to comply with the individual instruction or decision.

I. A health care provider or mental health treatment facility shall not require or prohibit the execution or revocation of an advance directive for mental health treatment as a condition for providing health care.

J. The Mental Health Care Treatment Decisions Act does not require or permit a mental health treatment facility or health care provider to provide any type of mental health treatment for which the mental health treatment facility or health care provider is not licensed, certified or otherwise authorized or permitted by law to provide.

History: Laws 2006, ch. 7, § 9.

24-7B-10. Health care information.

Unless otherwise specified in an advance directive for mental health treatment, a person then authorized to make mental health treatment decisions for a patient has the same rights as the patient to request, receive, examine, copy and consent to the disclosure of medical or any other health care information.

History: Laws 2006, ch. 7, § 10.

24-7B-11. Immunities.

A. A health care provider or mental health treatment facility acting reasonably and on reasonable grounds and in accordance with generally accepted health care standards applicable to the health care provider or mental health treatment facility is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying or attempting to comply with a mental health treatment decision of a person apparently having authority to make a mental health treatment decision for a patient;

(2) declining to comply with a mental health treatment decision of a person based on a belief that the person then lacked authority;

(3) complying or attempting to comply with an advance directive for mental health treatment and assuming that the directive was valid when made and has not been revoked or terminated;

(4) declining to comply with a mental health treatment directive as permitted; or

(5) complying or attempting to comply with any other provision of the Mental Health Care Treatment Decisions Act.

B. An individual acting as agent or guardian under the Mental Health Care Treatment Decisions Act is not subject to civil or criminal liability or to discipline for unprofessional conduct for mental health treatment decisions made in good faith.

History: Laws 2006, ch. 7, § 11.

24-7B-12. Prohibited practice.

A. No insurer or other provider of benefits regulated by the New Mexico Insurance Code [Chapter 59A NMSA 1978, except for Articles 30A and 42A] or a state agency shall require a person to execute or revoke an advance directive for mental health treatment as a condition for membership in, being insured for or receiving coverage or benefits under an insurance contract or plan.

B. No insurer may condition the sale, procurement or issuance of a policy, plan, contract, certificate or other evidence of coverage, or entry into a pension, profit-sharing, retirement, employment or similar benefit plan, upon the execution or revocation of an advance directive for mental health treatment; nor shall the existence of an advance directive for mental health treatment modify the terms of an existing policy, plan, contract, certificate or other evidence of coverage of insurance.

C. The provisions of this section shall be enforced by the superintendent of insurance under the New Mexico Insurance Code.

History: Laws 2006, ch. 7, § 12.

24-7B-13. Statutory damages.

A. A health care provider or mental health treatment facility that intentionally violates the Mental Health Care Treatment Decisions Act is subject to liability to the aggrieved individual for damages of five thousand dollars ($5,000) or actual damages resulting from the violation, whichever is greater, plus reasonable attorney fees.

B. A person who intentionally falsifies, forges, conceals, defaces or obliterates an individual's advance directive for mental health treatment or a revocation of an advance directive for mental health treatment without the individual's consent or a person who coerces or fraudulently induces an individual to give, revoke or not give or revoke an advance directive for mental health treatment is subject to liability to that individual for damages of five thousand dollars ($5,000) or actual damages resulting from the action, whichever is greater, plus reasonable attorney fees.

C. The damages provided in this section are in addition to other types of relief available under other law, including civil and criminal law and law providing for disciplinary procedures.

History: Laws 2006, ch. 7, § 13.

24-7B-14. Effect of copy.

A copy of a written advance directive for mental health treatment or revocation of an advance directive for mental health treatment has the same effect as the original.

History: Laws 2006, ch. 7, § 14.

24-7B-15. Effect of the Mental Health Care Treatment Decisions Act.

A. The Mental Health Care Treatment Decisions Act does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance directive for mental health treatment.

B. Death resulting from the withholding or withdrawal of health care in accordance with the Mental Health Care Treatment Decisions Act does not for any purpose:

(1) constitute a suicide, a homicide or other crime; or

(2) legally impair or invalidate a governing instrument, notwithstanding any term of the governing instrument to the contrary. "Governing instrument" means a deed, will, trust, insurance or annuity policy, account with POD (payment on death designation), security registered in beneficiary form (TOD), pension, profit-sharing, retirement, employment or similar benefit plan, instrument creating or exercising a

power of appointment or a dispositive, appointive or nominative instrument of any similar type.

C. The Mental Health Care Treatment Decisions Act does not authorize mercy killing, assisted suicide, euthanasia or the provision, withholding or withdrawal of health care, to the extent prohibited by other statutes of this state.

D. The Mental Health Care Treatment Decisions Act does not authorize or require a health care provider or mental health treatment facility to provide health care contrary to generally accepted health care standards applicable to the health care provider or mental health treatment facility.

E. The Mental Health Care Treatment Decisions Act does not authorize an agent to consent to the admission of an individual to a mental health treatment facility. If the individual's written advance directive for mental health treatment expressly permits treatment in a mental health treatment facility, the agent may present the individual to a facility for evaluation for admission.

F. The Mental Health Care Treatment Decisions Act does not affect other statutes of this state governing treatment for mental illness of an individual admitted to a mental health treatment facility, including involuntary commitment to a mental health treatment facility for mental illness.

History: Laws 2006, ch. 7, § 15.

24-7B-16. Transitional provisions.

A. An advance directive for mental health treatment is valid for purposes of the Mental Health Care Treatment Decisions Act if it complies with the provisions of that act, regardless of when or where executed or communicated.

B. The Mental Health Care Treatment Decisions Act does not impair a guardianship, living will, durable power of attorney, right-to-die statement or declaration or other advance directive for health care decisions that is in effect before July 1, 2006.

C. Any mental health treatment or psychiatric advance directive, durable power of attorney for health care decisions, living will, right-to-die statement or declaration or similar document that is executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction shall be deemed valid and enforceable in this state to the same extent as if it were properly made in this state.

History: Laws 2006, ch. 7, § 16.

ARTICLE 7C
End-of-Life Options

24-7C-1. Short title.

Chapter 24, Article 7C NMSA 1978 may be cited as the "End-of-Life Options Act" or the "Elizabeth Whitefield End-of-Life Options Act".

History: Laws 2021, ch. 132, § 1; 2023, ch. 133, § 1.

24-7C-2. Definitions.

As used in the End-of-Life Options Act:

A. "adult" means a resident of the state who is eighteen years of age or older;

B. "capacity" means an individual's ability to understand and appreciate health care options available to that individual, including significant benefits and risks, and to make and communicate an informed health care decision. A determination of capacity shall be made only according to professional standards of care and the provisions of Section 24-7A-11 NMSA 1978;

C. "health care entity" means an entity, other than an individual, that is licensed to provide any form of health care in the state, including a hospital, clinic, hospice agency, home health agency, long-term care agency, pharmacy, group medical practice, medical home or any similar entity;

D. "health care provider" means any of the following individuals authorized pursuant to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978] to prescribe a medication to be used in medical aid in dying:

(1) a physician licensed pursuant to the Medical Practice Act [Chapter 61, Article 6 NMSA 1978];

(2) an osteopathic physician licensed pursuant to the Osteopathic Medicine Act [Chapter 61, Article 10 NMSA 1978];

(3) a nurse licensed in advanced practice pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978]; or

(4) a physician assistant licensed pursuant to the Physician Assistant Act [61-6-7 to 61-6-10 NMSA 1978] or the Osteopathic Medicine Act;

E. "medical aid in dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to bring about a peaceful death;

F. "mental health professional" means a state-licensed psychiatrist, psychologist, master social worker, psychiatric nurse practitioner or professional clinical mental health counselor;

G. "prescribing health care provider" means a health care provider who prescribes medical aid in dying medication;

H. "qualified individual" means an individual who has met the requirements of Section 3 [24-7C-3 NMSA 1978] of the End-of-Life Options Act;

I. "self-administer" means taking an affirmative, conscious, voluntary action to ingest a pharmaceutical substance; and

J. "terminal illness" means a disease or condition that is incurable and irreversible and that, in accordance with reasonable medical judgment, will result in death within six months.

History: Laws 2021, ch. 132, § 2.

24-7C-3. Medical aid in dying; prescribing health care provider determination; form.

A prescribing health care provider may provide a prescription for medical aid in dying medication to an individual only after the prescribing health care provider has:

A. determined that the individual has:

(1) capacity;

(2) a terminal illness;

(3) voluntarily made the request for medical aid in dying; and

(4) the ability to self-administer the medical aid in dying medication;

B. provided medical care to the individual in accordance with accepted medical standards of care;

C. determined that the individual is making an informed decision after discussing with the individual the:

(1) individual's medical diagnosis and prognosis;

(2) potential risks associated with self-administering the medical aid in dying medication that the individual has requested the health care provider to prescribe;

(3) probable result of self-administering the medical aid in dying medication to be prescribed;

(4) individual's option of choosing to obtain the medical aid in dying medication and then deciding not to use it; and

(5) feasible alternative, concurrent or additional treatment opportunities, including hospice care and palliative care focused on relieving symptoms and reducing suffering;

D. determined in good faith that the individual's request does not arise from coercion or undue influence by another person;

E. noted in the individual's health record the prescribing health care provider's determination that the individual qualifies to receive medical aid in dying;

F. confirmed in the individual's health record that at least one physician or osteopathic physician licensed pursuant to the Medical Practice Act [Chapter 61, Article 6 NMSA 1978] or the Osteopathic Medicine Act [Chapter 61, Article 10 NMSA 1978] has determined, after conducting an appropriate examination, that the individual has capacity, a terminal illness and the ability to self-administer the medical aid in dying medication. That physician may be the prescribing health care provider pursuant to this section, the individual's hospice health care provider or another physician who meets the requirements of this subsection;

G. affirmed that the individual is:

(1) enrolled in a medicare-certified hospice program; or

(2) eligible to receive medical aid in dying after the prescribing health care provider has referred the individual to a consulting health care provider, who has experience with the underlying condition rendering the qualified individual terminally ill, and the consulting health care provider has:

(a) examined the individual;

(b) reviewed the individual's relevant medical records; and

(c) confirmed, in writing, the prescribing health care provider's prognosis that the individual is suffering from a terminal illness; and

H. provided substantially the following form to the individual and enters the form into the individual's health record after the form has been completed with all of the required signatures and initials:

"REQUEST FOR MEDICATION TO END MY LIFE IN A PEACEFUL MANNER

I, _____, am an adult of sound mind.

I am suffering from a terminal illness, which is a disease or condition that is incurable and irreversible and that, according to reasonable medical judgment, will result in my death within six months. My health care provider has determined that the illness is in its terminal phase. _____ (Patient Initials)

I have been fully informed of my diagnosis and prognosis, the nature of the medical aid in dying medication to be prescribed and the potential associated risks, the expected result and the feasible alternative, concurrent or additional treatment opportunities, including hospice care and palliative care focused on relieving symptoms and reducing suffering. _____ (Patient Initials)

I request that my health care provider prescribe medication that will end my life in a peaceful manner if I choose to self-administer the medication, and I authorize my health care provider to contact a willing pharmacist to fulfill this request. _____ (Patient Initials)

I understand that I have the right to rescind this request at any time. _____ (Patient Initials)

I understand the full import of this request, and I expect to die if I self-administer the medical aid in dying medication prescribed. I further understand that although most deaths occur within three hours, my death may take longer. My health care provider has counseled me about this possibility. _____ (Patient Initials)

I make this request voluntarily and without reservation.

Signed: _____

Date: _____ Time: _____

DECLARATION OF WITNESSES:

We declare that the person signing this request:

1. is personally known to us or has provided proof of identity;

2. signed this request in our presence;

3. appears to be of sound mind and not under duress, fraud or undue influence; and

4. is not a patient for whom either of us is a health care provider.

	Witness 1:	Witness 2:
Signature:	_____	_____
Printed Name:	_____	_____
Relationship to Patient:	_____	_____
Date:	_____	_____.

NOTE: No more than one witness shall be a relative by blood, marriage or adoption of the person signing this request. No more than one witness shall own, operate or be employed at a health care facility where the person signing this request is a patient or resident.".

History: Laws 2021, ch. 132, § 3.

24-7C-4. Determining capacity.

If an individual has a recent history of a mental health disorder or an intellectual disability that could cause impaired judgment with regard to end-of-life medical decision making, or if, in the opinion of the prescribing health care provider or consulting health care provider, an individual currently has a mental health disorder or an intellectual disability that may cause impaired judgment with regard to end-of-life medical decision making, the individual shall not be determined to have capacity to make end-of-life decisions until the:

A. health care provider refers the individual for evaluation by a mental health professional with the training and expertise to assess a person with such a disorder or disability; and

B. mental health professional determines the individual to have capacity to make end-of-life decisions after evaluating the individual during one or more visits with the individual.

History: Laws 2021, ch. 132, § 4.

24-7C-5. Waiting period.

A prescription for medical aid in dying medication shall:

A. not be filled until forty-eight hours after the prescription for medical aid in dying medication has been written, unless the qualified individual's prescribing health care provider has medically confirmed that the qualified individual may, within reasonable medical judgment, die before the expiration of the waiting period identified herein, in

which case, the prescription may be filled once the prescribing health care provider affirms that all requirements have been fulfilled pursuant to Section 3 [24-7C-3 NMSA 1978] of the End-of-Life Options Act; and

B. indicate the date and time that the prescription for medical aid in dying medication was written and indicate the first allowable date and time when it may be filled.

History: Laws 2021, ch. 132, § 5.

24-7C-6. Medical aid in dying; right to know.

A health care provider shall inform a terminally ill patient of all reasonable options related to the patient's care that are legally available to terminally ill patients that meet the medical standards of care for end-of-life care.

History: Laws 2021, ch. 132, § 6.

24-7C-7. Immunities; conscience-based decisions.

A. A person shall not be subject to criminal liability, licensing sanctions or other professional disciplinary action for:

(1) participating in medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act;

(2) being present when a qualified patient self-administers the prescribed medical aid in dying medication to end the qualified individual's life in accordance with the provisions of the End-of-Life Options Act; or

(3) refusing, for reasons of conscience, to participate in medical aid in dying in any way, which includes refusing to provide information on medical aid in dying to a patient and refusing to refer a patient to any entity or individual who is able and willing to assist the patient in obtaining medical aid in dying.

B. A health care entity, health insurer, managed care organization or health care provider shall not subject a person to censure, discipline, suspension, loss or denial of license, credential, privileges or membership or other penalty for participating, or refusing to participate, in the provision of medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act.

C. No health care provider who objects for reasons of conscience to participating in the provision of medical aid in dying shall be required to participate in the provision of medical aid in dying under any circumstance. If a health care provider is unable or unwilling to carry out an individual's request pursuant to the End-of-Life Options Act, that health care provider shall so inform the individual and refer the individual to a health

care provider who is able and willing to carry out the individual's request or to another individual or entity to assist the requesting individual in seeking medical aid in dying. If the health care provider transfers the individual's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the individual's relevant medical records to the new health care provider.

D. A health care entity shall not forbid or otherwise sanction a health care provider who provides medical aid in dying in accordance with the End-of-Life Options Act off the premises of the health care entity or when the health care provider is not acting within the normal course and scope of the health care provider's employment with the health care entity.

E. A health care entity may sanction a health care provider for participating in medical aid in dying on the premises of the prohibiting health care entity only if the health care entity has given written notice to the health care provider of the prohibiting entity's written policy forbidding participation in medical aid in dying and the health care provider participates in medical aid in dying:

(1) on the premises of the health care entity; or

(2) within the course and scope of the health care provider's employment for the health care entity.

F. Nothing in this section shall be construed to prevent:

(1) a health care provider from participating in medical aid in dying while the health care provider is acting outside the health care entity's premises or outside the course and scope of the health care provider's capacity as an employee; or

(2) an individual who seeks medical aid in dying from contracting with the individual's prescribing health care provider or consulting health care provider to act outside the course and scope of the provider's affiliation with the sanctioning health care entity.

G. A health care entity that imposes sanctions on a health care provider pursuant to the End-of-Life Options Act shall act reasonably, both substantively and procedurally, and shall be neither arbitrary nor capricious in its imposition of sanctions.

H. Participating, or not participating, in medical aid in dying shall not be the basis for a report of unprofessional conduct.

I. A health care entity that prohibits medical aid in dying shall accurately and clearly articulate this in an appropriate location on any website maintained by the entity and in any appropriate materials given to patients to whom the health care entity provides health care in words to be determined by the health care entity.

History: Laws 2021, ch. 132, § 7; 2023, ch. 133, § 2.

24-7C-8. Prohibited acts.

Nothing in the End-of-Life Options Act shall be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing or euthanasia. Actions taken in accordance with the End-of-Life Options Act shall not be construed, for any purpose, to constitute suicide, assisted suicide, euthanasia, mercy killing, homicide or adult abuse under the law.

History: Laws 2021, ch. 132, § 8.

ARTICLE 8
Family Planning

24-8-1. Short title.

This act [24-8-1 to 24-8-8 NMSA 1978] may be cited as the "Family Planning Act".

History: 1953 Comp., § 12-30-1, enacted by Laws 1973, ch. 107, § 1.

24-8-2. Definitions.

As used in the Family Planning Act:

A. "contraceptive procedures" means any medically accepted procedure to prevent pregnancy;

B. "family planning services" includes contraceptive procedures and services (diagnosis, treatment, supplies and follow-up), social services, educational and informational services;

C. "health facility" means a hospital, clinic, nursing home, intermediate care facility or pharmacy;

D. "medically indigent" means a person who has insufficient funds to pay for family planning services;

E. "local governmental units" means counties, municipalities and public school districts and any of their agencies, departments, commissions, committees, institutions and educational institutions;

F. "physician" means a person licensed or authorized to practice medicine or osteopathy under the provisions of Sections 61-6-1 through 61-6-28 and 61-10-1 [repealed] through 61-10-21 NMSA 1978; and

G. "state" means the state and its agencies, departments, commissions, committees, institutions and educational institutions.

History: 1953 Comp., § 12-30-2, enacted by Laws 1973, ch. 107, § 2.

24-8-3. Legislative findings; purpose of act.

A. The legislature finds that:

(1) family planning has been recognized as an essential component of standard health care and has been recognized nationally and internationally as a universal human right;

(2) continuing population growth causes or aggravates many social, economic and environmental problems, both in this state and in the nation;

(3) family planning services are not available as a practical matter to many persons in this state;

(4) it is desirable that family planning services be readily accessible to all who want and need them; and

(5) dissemination of information about family planning by the state and its local governmental units is consistent with public policy.

B. It is the purpose of the Family Planning Act to assure that comprehensive family planning services are accessible on a voluntary basis to all who want and need them.

History: 1953 Comp., § 12-30-3, enacted by Laws 1973, ch. 107, § 3.

24-8-4. Prohibition against interference with medical judgment of certain health care professionals.

The Family Planning Act does not prohibit or inhibit any person from refusing to provide any family planning service on the grounds that there are valid medical reasons for the refusal and that those reasons are based upon the judgment of a physician or a physician assistant, advanced practice registered nurse or certified nurse-midwife working within that person's scope of practice given in the specific case of the person for whom services are refused.

History: 1953 Comp., § 12-30-4, enacted by Laws 1973, ch. 107, § 4; 2015, ch. 116, § 9.

24-8-5. Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services.

Neither the state, its local governmental units nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite to the receipt of any requested family planning service except for:

A. a requirement of referral to a physician or a physician assistant, advanced practice registered nurse or certified nurse-midwife working within that person's scope of practice when the requested family planning service is something other than information about family planning or nonprescription items;

B. any requirement imposed by law or regulation as a prerequisite to the receipt of a family planning service; or

C. payment for the service when payment is required in the ordinary course of providing the particular service to the person involved.

History: 1953 Comp., § 12-30-5, enacted by Laws 1973, ch. 107, § 5; 2015, ch. 116, § 10.

24-8-6. Health facility licensure; affirmative statement of compliance required as condition of licensure; prohibition against certain policies of health facilities, state and local governmental units.

A. No health facility shall include in its bylaws or other governing policy statement a statement that:

(1) interferes with the physician-patient relationship in connection with the provision of any family planning service; or

(2) establishes or authorizes any standard or requirement in violation of Section 5 [24-8-5 NMSA 1978] of the Family Planning Act, provided that nothing in the Family Planning Act shall be construed to require any hospital or clinic that objects on moral or religious grounds to admit any person for the purpose of being sterilized.

B. Neither the state nor its local governmental units shall have any written or unwritten policy that interferes with the physician-patient relationship in connection with the provision of family planning services except for provisions required by law or regulations relating to payment from public funds to a provider of family planning services.

C. No license or a renewal of a license shall be issued by the state to a health facility if it is in violation of the provisions of Subsection A of this section.

History: 1953 Comp., § 12-30-6, enacted by Laws 1973, ch. 107, § 6.

24-8-7. Publicly funded family planning services; provision of certain services to medically indigent persons free of charge and to other persons at a cost consistent with their ability to pay.

To the extent that public funds are available, in any family planning services program operated by the state and its governmental units and in any family planning services program in which public funds are expended:

A. family planning services consisting only of information about family planning shall be furnished to persons free of charge; and

B. other family planning services shall be furnished to medically indigent persons free of charge and to all other persons at a cost consistent with their ability to pay.

History: 1953 Comp., § 12-30-7, enacted by Laws 1973, ch. 107, § 7.

24-8-8. Coordination of family planning services.

Any family planning services program developed or operated by the state or its local governmental units shall be developed and operated in coordination with other public and private family planning services programs existing in the state.

History: 1953 Comp., § 12-30-8, enacted by Laws 1973, ch. 107, § 8.

ARTICLE 9
Sterilization

24-9-1. Sterilization; consent of abandoning spouse unnecessary.

Any person, otherwise capable of consenting to medical treatment, need not obtain the consent of his spouse for his voluntary medical sterilization if such person has been abandoned by his spouse.

History: 1953 Comp., § 12-3-43, enacted by Laws 1971, ch. 14, § 3; 1973, ch. 266, § 1.

ARTICLE 9A
Maternal, Fetal and Infant Experimentation

24-9A-1. Definitions.

As used in the Maternal, Fetal and Infant Experimentation Act:

A. "viability" means that stage of fetal development when the unborn child is potentially able to live outside the mother's womb, albeit with artificial aid;

B. "conception" means the fertilization of the ovum of a human female by the sperm of a human male;

C. "health" means physical or mental health;

D. "clinical research" means any biomedical or behavioral research involving human subjects, including the unborn, conducted according to a formal procedure. The term is to be construed liberally to embrace research concerning all physiological processes in human beings and includes research involving human in vitro fertilization, but shall not include diagnostic testing, treatment, therapy or related procedures conducted by formal protocols deemed necessary for the care of the particular patient upon whom such activity is performed and shall not include human in vitro fertilization performed to treat infertility; provided that this procedure shall include provisions to ensure that each living fertilized ovum, zygote or embryo is implanted in a human female recipient, and no physician may stipulate that a woman must abort in the event the pregnancy should produce a child with a disability. Provided that emergency medical procedures necessary to preserve the life or health of the mother or the fetus shall not be considered to be clinical research;

E. "subject at risk", "subject" or "at risk" means any person who may be exposed to the likelihood of injury, including physical or psychological injury, as a consequence of participation as a subject in:

(1) any research, development or related activity that departs from the application of those established and accepted methods deemed necessary to meet the person's needs;

(2) controlled research studies necessary to establish accepted methods designed to meet the person's needs; or

(3) research activity that poses a significant risk to the subject;

F. "significant risk" means an activity that is likely to cause disfigurement or loss or impairment of the function of any member or organ;

G. "fetus" means the product of conception from the time of conception until the expulsion or extraction of the fetus or the opening of the uterine cavity, but shall not include the placenta, extraembryonic membranes, umbilical cord, extraembryonic fluids and their resident cell types and cultured cells;

H. "live-born infant" means an offspring of a person that exhibits heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles or pulsation of the umbilical cord if still attached to the infant ex utero; provided the Maternal, Fetal and Infant Experimentation Act does not apply to a fetus or infant absent the characteristics set forth in this subsection;

I. "infant" means an offspring of a human being from the time it is born until the end of its first chronological year;

J. "born" means the time the head or any other part of the body of the fetus emerges from the vagina or the time the uterine cavity is opened during a caesarean section or hysterotomy; and

K. "in vitro fertilization" means any fertilization of human ova that occurs outside the body of a female, either through admixture of donor human sperm and ova or by any other means.

History: Laws 1979, ch. 132, § 1; 1985, ch. 98, § 1; 2007, ch. 46, § 15.

24-9A-2. Pregnant woman.

A. No woman, known to be pregnant according to generally accepted medical standards, shall be involved as a subject in any clinical research activity unless:

(1) the purpose of the activity is to meet the health needs of the mother or the fetus and the fetus will be placed at risk only to the minimum extent necessary to meet such needs; or

(2) there is no significant risk to the fetus.

B. An activity permitted under Subsection A of this section may be conducted only if the mother is legally competent and has given her informed consent after having been fully informed regarding possible impact on the fetus.

History: Laws 1979, ch. 132, § 2.

24-9A-3. Fetus.

A. No fetus shall be involved as a subject in any clinical research activity unless the purpose of the activity is to meet the health needs of the particular fetus and the fetus will be placed at risk only to the minimum extent necessary to meet such needs or no significant risk to the fetus is imposed by the research activity.

B. An activity permitted under Subsection A of this section shall be conducted only if the mother is legally competent and has given her informed consent.

History: Laws 1979, ch. 132, § 3.

24-9A-4. Live-born infant.

A. No live-born infant shall be involved as a subject in any clinical research activity unless the purpose of the activity is to meet the health needs of that particular infant, and the infant will be placed at risk only to the minimum extent necessary to meet such needs or no significant risk to such infant is imposed by the research activity.

B. An activity permitted under Subsection A of this section shall be conducted only if:

(1) the nature of the investigation is such that adults or mentally competent persons would not be suitable subjects; and

(2) the mother or father or the infant's legal guardian is mentally competent and has given his or her informed consent.

History: Laws 1979, ch. 132, § 4.

24-9A-5. Research activity.

A. No clinical research activity involving fetuses, live-born infants or pregnant women shall be conducted unless:

(1) appropriate studies on animals and nonpregnant human beings have been completed;

(2) anyone engaged in conducting the research activity will have no part in:

(a) any decisions as to the timing, method and procedures used to terminate the pregnancy; and

(b) determining the viability of the fetus at the termination of the pregnancy; and

(3) no procedural changes which may cause significant risk to the fetus or the pregnant woman will be introduced into the procedure for terminating the pregnancy solely in the interest of the research activity.

B. No inducements, monetary or otherwise, shall be offered to any woman to terminate her pregnancy for the purpose of subjecting her fetus or live-born infant to clinical research activity.

C. No consent to involve a pregnant woman, fetus or infant as a subject in clinical research activity shall be valid unless the pregnant woman or the parent or guardian of the infant has been fully informed of the following:

(1) a fair explanation of the procedures to be followed and their purposes, including identification of any procedures which are experimental;

(2) a description of any attendant discomforts and risks reasonably to be expected;

(3) a description of any benefits reasonably to be expected;

(4) a disclosure of any appropriate alternative procedures that might be advantageous for the subject;

(5) an offer to answer any inquiries concerning the procedure; and

(6) an instruction that the person who gave the consent is free to withdraw his consent and to discontinue participation in the project or activity at any time without prejudice to the subject.

History: Laws 1979, ch. 132, § 5.

24-9A-6. Penalty.

Whoever knowingly and willfully violates the provisions of Section 2, 3 or 4 [24-9A-2, 24-9A-3 or 24-9A-4 NMSA 1978] of this act shall be deemed guilty of a misdemeanor, and upon conviction shall be punished by imprisonment in the county jail for a definite term of less than one year, or to the payment of a fine of not more than one thousand dollars ($1,000), or to both imprisonment and fine in the discretion of the judge.

History: Laws 1979, ch. 132, § 6.

24-9A-7. Short title.

Sections 1 through 7 [24-9A-1 to 24-9A-7 NMSA 1978] of this act may be cited as the "Maternal, Fetal and Infant Experimentation Act".

History: Laws 1979, ch. 132, § 7.

ARTICLE 10
Consent to Medical Care; Emergency Care; Transfusions

24-10-1. Emancipated minors; hospital, medical and surgical care.

Notwithstanding any other provision of the law, and without limiting cases in which consent may otherwise be obtained or is not required, any emancipated minor or any minor who has contracted a lawful marriage may give consent to the furnishing of hospital, medical and surgical care to such minor, and the consent is not subject to disaffirmance because of minority. The consent of a parent of an emancipated minor or of a minor who has contracted a lawful marriage is not necessary in order to authorize hospital, medical and surgical care. For the purposes of this section only, subsequent judgment of annulment of the marriage or judgment of divorce shall not deprive the minor of his adult status once attained.

History: 1953 Comp., § 12-12-1, enacted by Laws 1963, ch. 32, § 1; recompiled as 1953 Comp., § 12-25-1, by Laws 1972, ch. 51, § 9.

24-10-2. Consent for emergency attention by person in loco parentis.

Notwithstanding any other provision of the law, in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting thereto, after reasonable efforts have been made under the circumstances, consent for the emergency attention may be given by any person standing in loco parentis to the minor.

History: 1953 Comp., § 12-12-2, enacted by Laws 1963, ch. 32, § 2; recompiled as 1953 Comp., § 12-25-2, by Laws 1972, ch. 51, § 9.

24-10-3. Persons coming to aid or rescue of another rendering emergency care; release from liability.

No person who comes to the aid or rescue of another person by providing care or assistance in good faith at or near the scene of an emergency, as defined in Section 24-10-4 NMSA 1978, shall be held liable for any civil damages as a result of any action or omission by that person in providing that care or assistance, except when liable for an act of gross negligence; but nothing in this section applies to the provision of emergency care or assistance when it is rendered for remuneration or with the expectation of remuneration or is rendered by a person or agent of a principal who was at the scene of the accident or emergency because he or his principal was soliciting business or performing or seeking to perform some services for remuneration.

History: 1953 Comp., § 12-12-3, enacted by Laws 1963, ch. 59, § 1; recompiled as 1953 Comp., § 12-25-3, by Laws 1972, ch. 51, § 9; 1997, ch. 86, § 1.

24-10-4. Emergency defined.

As used in Sections 24-10-3 and 24-10-4 NMSA 1978, "emergency" means an unexpected occurrence of injury or illness occurring in public or private places to a person that results from:

A. motor vehicle accidents and collisions;

B. acts of God; and

C. other accidents and events of similar nature.

History: 1953 Comp., § 12-12-4, enacted by Laws 1963, ch. 59, § 2; recompiled as 1953 Comp., § 12-25-4, by Laws 1972, ch. 51, § 9; 1999, ch. 141, § 1.

24-10-5. Transfusions; limited liability.

The procuring, furnishing, donating, processing, distributing or using of human whole blood, plasma, blood products, blood derivatives, human tissue or organs or any component thereof shall not give rise to any implied warranties of any type, and the doctrine of strict tort liability shall not be applicable to the transmission of hepatitis or human immunodeficiency virus in the blood, plasma, blood products, blood derivatives, human tissue or organs or any component thereof. Nothing in this section shall be construed as affecting the liability of any person, firm, corporation or other organization for negligence or willful misconduct.

History: 1953 Comp., § 12-12-5, enacted by Laws 1971, ch. 119, § 1; 1953 Comp., § 12-25-5 by Laws 1972, ch. 51, § 9; 1978 Comp., § 24-10-5; Laws 1987, ch. 104, § 1.

24-10-6. Blood donation; minors.

A. A minor who is at least seventeen years of age may donate blood to a licensed, accredited or approved blood bank, storage facility or hospital without parental consent.

B. A minor shall not receive monetary payment from a licensed, accredited or approved blood bank, storage facility or hospital for a donation of blood or blood components.

History: Laws 2003, ch. 79, § 1.

ARTICLE 10A
Emergency Medical Services Fund

24-10A-1. Short title.

Chapter 24, Article 10A NMSA 1978 may be cited as the "Emergency Medical Services Fund Act".

History: 1978 Comp., § 24-10A-1, enacted by Laws 1978, ch. 178, § 1; 1987, ch. 246, § 1.

24-10A-2. Purpose of act.

The purpose of the Emergency Medical Services Fund Act is to make money available to municipalities and counties for use in the establishment and enhancement of local emergency medical services, statewide emergency medical services and trauma services in order to reduce injury and loss of life.

History: 1978 Comp., § 24-10A-2, enacted by Laws 1978, ch. 178, § 2; 1987, ch. 246, § 2; 1994, ch. 61, § 1; 2001, ch. 258, § 1; 2001, ch. 273, § 1.

24-10A-2.1. Definitions.

As used in the Emergency Medical Services Fund Act:

A. "bureau" means the emergency medical systems bureau of the department;

B. "committee" means the statewide emergency medical services advisory committee appointed pursuant to the provisions of Section 24-10B-7 NMSA 1978;

C. "department" means the department of health;

D. "fund" means the emergency medical services fund;

E. "local recipient" means a publicly owned or contracted ambulance or air ambulance service, medical rescue service, fire department rescue service, regionalized emergency medical service agency; or other prehospital emergency medical service care provider based in the state:

(1) that routinely responds to an individual's need for immediate medical care in order to prevent loss of life or aggravation of physical or psychological illness or injury;

(2) whose application for funding through the Emergency Medical Services Fund Act is sponsored by a municipality or county; and

(3) that meets department guidelines for certification, including:

(a) personnel training;

(b) participation in emergency medical service data collection and submission to the state emergency medical systems database;

(c) participation in local design and planning for efficient delivery of emergency medical services;

(d) participation in mutual aid agreements and medical control; and

(e) participation in medical control for emergency medical services;

F. "municipality" means an incorporated city, town or village;

G. "regionalized emergency medical service agency" means a rural or frontier emergency medical service agency composed of multiple geographic districts with response area populations of fewer than two hundred fifty people per square mile;

H. "secretary" means the secretary of health; and

I. "tribe" means a federally recognized Native American nation, tribe or pueblo located wholly or partially in the state.

History: Laws 1994, ch. 61, § 2; 2001, ch. 258, § 2; 2001, ch. 273, § 2; 2017, ch. 87, § 23.

24-10A-3. Emergency medical services fund created; funding.

A. The "emergency medical services fund" is created in the state treasury. Money in the fund shall not revert at the end of any fiscal year. Money appropriated to the fund or accruing to it through gifts, grants, fees or bequests shall be deposited in the fund. Interest earned on investment of the fund shall be credited to the general fund. Disbursements from the fund shall be made upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary or the secretary's authorized representative.

B. The bureau shall administer the fund and provide for the distribution of the fund pursuant to the Emergency Medical Services Fund Act and rules adopted pursuant to the provisions of that act.

C. In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution.

D. In any fiscal year, no more than:

(1) twenty-two percent of the fund may be used for emergency medical services system improvement projects, including the purchase of emergency medical services vehicles, local and statewide emergency medical services system support projects, the statewide trauma care system program and the emergency medical dispatch agency support program; and

(2) three percent of the fund may be used by the bureau for administrative costs, including monitoring and providing technical assistance.

E. In any fiscal year, money in the fund that is not distributed pursuant to the provisions of Subsection D of this section may be distributed pursuant to the provisions of Subsection C of this section.

History: 1978 Comp., § 24-10A-3, enacted by Laws 1978, ch. 178, § 3; 1987, ch. 246, § 3; 1989, ch. 324, § 18; 1994, ch. 61, § 3; 2001, ch. 258, § 3; 2001, ch. 273, § 3; 2017, ch. 87, § 24.

24-10A-3. Emergency medical services fund created; funding. (Effective July 1, 2025.)

A. The "emergency medical services fund" is created in the state treasury. Money in the fund shall not revert at the end of any fiscal year. Money appropriated to the fund or accruing to it through distributions, gifts, grants, fees or bequests shall be deposited in the fund. Interest earned on investment of the fund shall be credited to the general fund. Disbursements from the fund shall be made upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary or the secretary's authorized representative.

B. The bureau shall administer the fund and provide for the distribution of the fund pursuant to the Emergency Medical Services Fund Act and rules adopted pursuant to the provisions of that act.

C. In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution.

D. In any fiscal year, no more than:

(1) twenty-two percent of the fund may be used for emergency medical services system improvement projects, including the purchase of emergency medical services vehicles, local and statewide emergency medical services system support projects, the statewide trauma care system program and the emergency medical dispatch agency support program; and

(2) three percent of the fund may be used by the bureau for administrative costs, including monitoring and providing technical assistance.

E. In any fiscal year, money in the fund that is not distributed pursuant to the provisions of Subsection D of this section may be distributed pursuant to the provisions of Subsection C of this section.

History: *1978 Comp., § 24-10A-3, enacted by Laws 1978, ch. 178, § 3; 1987, ch. 246, § 3; 1989, ch. 324, § 18; 1994, ch. 61, § 3; 2001, ch. 258, § 3; 2001, ch. 273, § 3; 2017, ch. 87, § 24; 2024, ch. 27, § 2.*

24-10A-3.1. Regulations.

The department shall adopt regulations pursuant to Subsection E of Section 9-7-6 NMSA 1978 to carry out the provisions of the Emergency Medical Services Fund Act.

History: Laws 1994, ch. 61, § 13.

24-10A-4. Funding program; purpose; determination of needs.

A. The "local emergency medical services funding program" is created. The program shall provide for the:

(1) establishment or enhancement of local emergency medical services, including the use of advanced technology equipment;

(2) operational costs other than salaries and benefits of local emergency medical services personnel;

(3) purchase, repair and maintenance of emergency medical services vehicles, equipment and supplies, including the use of advanced technology equipment; and

(4) training and licensing of local emergency medical services personnel.

B. Annually on or before June 1, the bureau shall consider and determine, in accordance with the formula adopted by rule of the department, the amount of distribution to municipalities and counties that have applied for money from the fund. In making its determination, the bureau shall ensure that no municipality or county receives money from the fund for the purpose of accumulation as defined by rule of the

department, except as waived by the bureau in writing for good cause shown. The bureau shall also ensure that each local recipient is in compliance with the rules of the department.

History: 1978 Comp., § 24-10A-4, enacted by Laws 1978, ch. 178, § 4; 1979, ch. 141, § 1; 1987, ch. 246, § 4; 1994, ch. 61, § 4; 2000, ch. 16, § 1; 2001, ch. 258, § 4; 2001, ch. 273, § 4.

24-10A-4.1. Emergency medical services system improvement projects.

A. Applications for emergency medical services system improvement projects shall be submitted separately from applications for the local emergency medical services funding program. The bureau shall award emergency medical services system improvement projects after a review of the applications. The awards shall be made based on a priority ranking, demonstrated need for funding and recommendations from the committee. Money awarded shall be used in compliance with applicable rules.

B. Applications for funding to purchase emergency medical services vehicles shall be submitted by municipalities or counties on behalf of local recipients. The municipality or county shall commit to providing matching funds of at least twenty-five percent of the cost of purchasing the vehicle.

C. Applications for funding of local and statewide projects shall demonstrate the need for funding and a plan to use the funding to enhance or better integrate local emergency medical services systems or to improve the health, safety and training of emergency medical services technicians statewide.

D. A statewide trauma care system program shall be developed and determined by the bureau in consultation with the committee. The statewide trauma care system program shall provide for the support, development and expansion of the statewide trauma care system in accordance with rules adopted by the department.

E. The emergency medical dispatch agency support program shall fund allowable costs of dispatch agencies that meet criteria established pursuant to rules by the department.

History: Laws 1994, ch. 61, § 10; 2001, ch. 258, § 5; 2001, ch. 273, § 5.

24-10A-4.2. Mutual aid agreements; regionalized, integrated response plans.

Municipalities, counties, tribes and local recipients may develop mutual aid agreements and regionalized, integrated response plans with other municipalities, counties, tribes and local recipients for the purpose of ensuring that adequate

emergency medical services coverage exists throughout the state. For the benefit of the public, equipment and other emergency medical services resources obtained through money from the fund shall be shared among the parties to a mutual aid agreement or regionalized, integrated response plan.

History: Laws 1994, ch. 61, § 11; 2017, ch. 87, § 25.

24-10A-5. Funding program; awards; appeals.

The bureau shall promptly notify each municipality and county that has applied for money and the local recipient of the bureau's determination to grant or deny an application for funding through the local emergency medical services funding program. A municipality or county may appeal a determination of the bureau within ten working days after notification of the determination. The bureau shall refer the appeal to the committee for its review and recommendation. The committee shall make its recommendation to the secretary, who shall make a final determination about whether to grant or deny an application for funding. The secretary shall notify the appellant of the secretary's decision within thirty days of the date on which the committee has notified the secretary of its recommendation.

History: 1978 Comp., § 24-10A-5, enacted by Laws 1978, ch. 178, § 5; 1987, ch. 246, § 5; 1994, ch. 61, § 5; 2017, ch. 87, § 26.

24-10A-6. Distribution of fund.

On or before August 31, the local emergency medical services funding program distribution shall be made to each municipality and county as determined by the department. No more than one percent of the amount appropriated to the local emergency medical services funding program shall be distributed from the fund to the benefit of a single local recipient in any fiscal year pursuant to the local emergency medical services funding program, with the exception of a regionalized emergency medical service agency, to ensure that appropriate emergency medical service is available statewide.

History: 1978 Comp., § 24-10A-6, enacted by Laws 1978, ch. 178, § 6; 1979, ch. 141, § 2; 1987, ch. 246, § 6; 1994, ch. 61, § 6; 2001, ch. 258, § 6; 2001, ch. 273, § 6; 2017, ch. 87, § 27.

24-10A-7. Funding program; expenditures from fund.

Any money distributed from the fund for the purposes of the local emergency medical services funding program shall be expended only for those purposes.

History: 1978 Comp., § 24-10A-7, enacted by Laws 1978, ch. 178, § 7; 1979, ch. 141, § 3; 1987, ch. 246, § 7; 1994, ch. 53, § 1; 1994, ch. 61, § 7.

24-10A-8. Funding program; control of expenditures.

Money distributed from the fund shall be expended only for the purposes stated in the application to the bureau and shall be expended on the authorization of the chief executive of the municipality or county upon vouchers issued by its treasurer.

History: 1978 Comp., § 24-10A-8, enacted by Laws 1978, ch. 178, § 8; 1987, ch. 246, § 8; 1994, ch. 61, § 8; 2017, ch. 87, § 28.

24-10A-9. Funding program; inspection by the bureau.

The bureau and its designated agents have the authority at all normal hours of operation to enter in and upon all buildings and premises where emergency medical services vehicles, equipment and supplies acquired with expenditures from the fund are located for the purposes of examination and inspection.

History: 1978 Comp., § 24-10A-9, enacted by Laws 1978, ch. 178, § 9; 1987, ch. 246, § 9; 1994, ch. 61, § 9.

24-10A-10. Loss of funding eligibility.

A municipality, county or local recipient that the bureau finds has expended money in violation of the Emergency Medical Services Fund Act may be ineligible to receive funding from the bureau for a period of not less than one year or more than three years, as determined by the bureau in accordance with rules and regulations adopted by the department.

History: Laws 1994, ch. 61, § 12.

ARTICLE 10B
Emergency Medical Services System

24-10B-1. Short title.

Chapter 24, Article 10B NMSA 1978 may be cited as the "Emergency Medical Services Act".

History: Laws 1983, ch. 190, § 1; 2014, ch. 47, § 1.

24-10B-2. Purpose.

The purpose of the Emergency Medical Services Act is to enhance and regulate a comprehensive emergency medical services system in the state as set forth in that act. Nothing in the Emergency Medical Services Act shall be construed to preclude a local

emergency medical services system from adopting standards that are more stringent than those authorized by the Emergency Medical Services Act.

History: Laws 1983, ch. 190, § 2; 1993, ch. 161, § 1; 2003, ch. 243, § 1.

24-10B-3. Definitions.

As used in the Emergency Medical Services Act:

A. "academy" means an emergency medical services training program administered through the department of emergency medicine of the university of New Mexico school of medicine;

B. "advance directive" means a written instruction, such as a living will, durable power of attorney for health care or emergency medical services do not resuscitate form recognizable under state law and relating to the provision of health care when an individual is incapacitated;

C. "air ambulance service" means any governmental or private service that provides air transportation specifically designed to accommodate the medical needs of a person who is ill, injured or otherwise mentally or physically incapacitated and who requires in-flight medical supervision;

D. "approved emergency medical services training program" means an emergency medical services training program that is sponsored by a post-secondary educational institution, accredited by a national educational accrediting organization for emergency medical services or active in the accreditation process, and is approved by the joint organization on education committee and participates in the joint organization on education committee;

E. "bureau" means the injury prevention and emergency medical services bureau of the public health division of the department;

F. "certified emergency medical service" means an organization that meets minimum standards to provide emergency services and is approved by the bureau, including emergency medical dispatch agencies, pre-hospital or interfacility care services and special event services organized to provide emergency medical services;

G. "critical incident stress management program" means a program of preventive education and crisis intervention intended to reduce the negative effects of critical stress on emergency responders;

H. "department" means the department of health;

I. "emergency medical dispatch" means an advanced form of dispatch communications used to improve emergency medical services response to medical and

traumatic emergencies that utilizes specially trained emergency medical dispatchers, in accordance with an emergency medical dispatch priority reference system and the department-approved scopes of practice;

J. "emergency medical dispatcher" means a person who is trained and licensed pursuant to Subsection F of Section 24-10B-4 NMSA 1978 to receive calls for emergency medical assistance, provide pre-arrival medical instructions, dispatch emergency medical assistance and coordinate its response;

K. "emergency medical services" means the services rendered by providers in response to an individual's need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury;

L. "emergency medical services first responder" means a person who is licensed by the department and who functions within the emergency medical services system to provide initial emergency aid;

M. "emergency medical services system" means a coordinated system of health care delivery that responds to the needs of the sick and injured and includes emergency medical services;

N. "emergency medical technician" means a provider who has been licensed by the department to provide patient care;

O. "health care facility" means a hospital, clinic or other entity licensed or approved by the department;

P. "injury prevention" means to promote and implement efforts to reduce the risk and severity of intentional and unintentional injuries;

Q. "medical direction" means guidance or supervision provided by a physician to a provider or emergency medical services system and that may include authority over and responsibility for emergency medical dispatch, direct patient care and transport of patients, arrangements for medical control and all other aspects of patient care delivered by a provider;

R. "paramedic" means a provider licensed at that level by the department to provide patient care;

S. "physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico;

T. "protocol" means a predetermined, written medical care plan and includes standing orders;

U. "provider" means a person who has been licensed by the department to provide patient care pursuant to the Emergency Medical Services Act;

V. "regional office" means an emergency medical services planning and development agency formally recognized and supported by the bureau;

W. "secretary" means the secretary of health;

X. "special skills" means a set of procedures or therapies that are beyond the scope of practice of a given level of licensure and that have been approved by the medical direction committee for use by a specified provider; and

Y. "state emergency medical services medical director" means a physician designated by the department to provide overall medical direction to the statewide emergency medical services system, whose duties include serving as a liaison to the medical community and chairing the medical direction committee.

History: 1978 Comp., § 24-10B-3, enacted by Laws 1993, ch. 161, § 2; 2003, ch. 243, § 2.

24-10B-4. Bureau; duties.

The bureau is designated as the lead agency for the emergency medical services system, including injury prevention, and shall establish and maintain a program for regional planning and development, improvement, expansion and direction of emergency medical services throughout the state, including:

A. design, development, implementation and coordination of emergency medical services communications systems to join the personnel, facilities and equipment of a given region or system that will allow for medical direction;

B. provision of technical assistance to the department of transportation for further development and implementation of standards for certification of ambulance services, vehicles and equipment;

C. development of requirements for the collection of data and statistics to evaluate the availability, operation and quality of providers in the state;

D. adoption of rules for emergency medical services medical direction upon the recommendation of the medical direction committee;

E. approval of continuing education programs for emergency medical services personnel;

F. adoption of rules pertaining to the training and licensure of emergency medical dispatchers and their instructors;

G. adoption of rules based upon the recommendations of a trauma advisory committee, for implementation and monitoring of a statewide, comprehensive trauma care system, including:

(1) minimum standards for designation or retention of designation as a trauma center or a participating trauma facility;

(2) pre-hospital care management guidelines for the triage and transportation of traumatized persons;

(3) establishment for interfacility transfer criteria and transfer agreements;

(4) standards for collection of data relating to trauma system operation, patient outcome and trauma prevention; and

(5) creation of a state trauma care plan;

H. adoption of rules, based upon the recommendations of the air transport advisory committee, for the certification of air ambulance services;

I. adoption of rules pertaining to authorization of providers to honor advance directives, such as emergency medical services do not resuscitate forms, to withhold or terminate care in certain pre-hospital or interfacility circumstances, as guided by local medical protocols;

J. operation of a critical incident stress management program for emergency providers utilizing specifically trained volunteers who shall be considered public employees for the purposes of the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978] when called upon to perform their duties;

K. adoption of rules to establish a cardiac arrest targeted response program pursuant to the Cardiac Arrest Response Act [24-10C-1 to 24-10C-7 NMSA 1978], including registration of automated external defibrillator programs, maintenance of equipment, data collection, approval of automated external defibrillator training programs and a schedule of automated external defibrillator program registration fees;

L. adoption of rules for the administration of an emergency medical services certification program for certified emergency medical services; and

M. promoting, developing, implementing, coordinating and evaluating risk reduction and injury prevention systems.

History: Laws 1983, ch. 190, § 4; 1993, ch. 161, § 3; 1999, ch. 94, § 8; 2003, ch. 243, § 3; 2023, ch. 100, § 12.

24-10B-4.1. Records confidentiality.

A. Any files or records in the possession of the bureau, a regional office or a provider containing identifying information about individuals requesting or receiving treatment or other health services and any unsubstantiated complaints received by the bureau regarding any provider shall be confidential and not subject to public inspection.

B. Such files, records and complaints may be subject to subpoena for use in any pending cause in any administrative proceeding or in any of the courts of this state, unless otherwise provided by law.

History: Laws 2003, ch. 243, § 11.

24-10B-4.2. Approved training programs.

Approved emergency medical services training programs for providers are an integral part of the emergency medical services system and the programs shall include:

A. improving and expanding emergency medical services within regions through focused emergency medical services educational activities;

B. furthering the knowledge base of emergency medical services education; and

C. securing physicians as medical directors to advise approved training programs in medical matters and to serve as liaison to the state emergency medical services medical director and the medical community as a whole.

History: Laws 2003, ch. 243, § 12.

24-10B-4.3. Regional offices; duties.

A. Regional offices may be established by the department to assist the bureau to provide regional planning and development, improvement, expansion and direction of emergency medical services and injury prevention in their respective geographic regions.

B. Regional offices may provide technical support and assistance, training coordination, outreach, advocacy, prevention and public education and leadership to communities and providers in their respective geographic regions. They may also provide specific support to the bureau for functions such as licensing examination, planning, evaluation and Emergency Medical Services Fund Act [Chapter 24, Article 10A NMSA 1978] administration.

History: Laws 2003, ch. 243, § 13.

24-10B-5. Licensure required; penalty.

A. The department shall by rule adopt and enforce licensure requirements, including minimum standards for training, continuing education and disciplinary actions consistent with the Uniform Licensing Act [61-1-1 to 61-1-31 NMSA 1978], for all persons who provide emergency medical services within the state, irrespective of whether the services are remunerated. The rules shall include authorization for the bureau to issue at least annually an updated list of skills, techniques and medications approved for use at each level of licensure. The secretary may waive licensure requirements as needed during a declared emergency.

B. Licensed emergency medical technicians may function within health care facilities under their licensure and approved New Mexico emergency medical services scope of practice. Nothing in this subsection shall prohibit a health care facility from assigning additional duties and responsibilities in accordance with law. This subsection shall not expand the New Mexico emergency medical services scope of practice under the emergency medical technician's license.

C. In addition to the requirements specified in Subsection A of this section, the department may:

(1) prohibit the use of "emergency medical dispatcher", "emergency medical technician", "emergency medical services first responder", "paramedic" or similar terms connoting expertise in providing emergency medical services by any person not licensed or certified under the Emergency Medical Services Act;

(2) deny, suspend or revoke licensure in accordance with the provisions of the Uniform Licensing Act; and

(3) establish a schedule of reasonable fees for application, examination or licensure and regular renewal thereof.

D. Any person who represents himself to be an "emergency medical dispatcher", "emergency medical technician-basic", "emergency medical technician-intermediate", "emergency medical technician-paramedic", "emergency medical services first responder" or "paramedic", or who uses similar terms connoting expertise in providing emergency medical services while not currently licensed under the Emergency Medical Services Act is guilty of a misdemeanor.

History: Laws 1983, ch. 190, § 5; 1993, ch. 161, § 4; 2003, ch. 243, § 4.

24-10B-5.1. Licensing commission established.

A. The secretary shall appoint an "emergency medical services licensing commission", which shall be staffed by the bureau and composed of one lay person, three emergency medical technicians, one from each level of licensure, and three physicians, at least two of whom shall have expertise in emergency medicine and who

are appointed from a list proposed by the New Mexico chapter of the American college of emergency physicians.

B. The composition of the emergency medical services licensing commission shall reflect geographic diversity and both public and private interests. The members shall serve for three-year staggered terms. The duties of and procedures for the emergency medical services licensing commission shall be delineated in rules promulgated pursuant to Subsection A of Section 24-10B-5 NMSA 1978. Such duties include:

(1) providing a forum for the receipt of public comment regarding emergency medical services licensing matters;

(2) oversight of the bureau's licensure functions;

(3) receiving complaints, directing investigations and authorizing the initiation of actions by the bureau regarding contemplated refusal to grant initial licensure and for disciplinary actions against licensees; and

(4) the granting of waivers, for good cause shown, of rules pertaining to licensure renewal.

C. The emergency medical services licensing commission may compel the production of books, records and papers pertinent to any investigation authorized by the Emergency Medical Services Act and may seek enforcement of any subpoena so issued through the district court in the county in which the custodian of the document is located in camera.

D. The emergency medical services licensing commission shall meet as needed, but not less frequently than semiannually. The emergency medical services licensing commission shall be subject to the provisions of the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

History: Laws 1993, ch. 161, § 5; 2003, ch. 243, § 5.

24-10B-5.2. Criminal history background screening.

A. The department is authorized to obtain the criminal history records of applicants and licensees and to exchange fingerprint data directly with the federal bureau of investigation, the department of public safety and any other law enforcement agency or organization. The department shall require fingerprinting of applicants and licensees for the purposes of this section.

B. The secretary shall adopt and promulgate rules to:

(1) require criminal history background checks for applicants and licensees;

(2) identify the information from a criminal history background check that may form the basis of a denial, suspension or revocation of licensure or any other disciplinary action; and

(3) otherwise carry out the provisions of this section.

C. The department shall comply with applicable confidentiality requirements of the department of public safety and the federal bureau of investigation regarding the dissemination of criminal history background check information.

D. An applicant or licensee whose license is denied, suspended or revoked, or who is otherwise disciplined based on information obtained in a criminal history background check, shall be entitled to review the information obtained pursuant to this section and to appeal the decision pursuant to the Uniform Licensing Act [61-1-1 to 61-1-31 NMSA 1978].

E. The applicant or licensee shall bear any costs associated with ordering or conducting criminal history background checks.

F. The provisions of the Criminal Offender Employment Act [28-2-1 to 28-2-6 NMSA 1978] shall govern any consideration of criminal history records required or permitted by the Emergency Medical Services Act.

G. As used in this section:

(1) "applicant" means a person applying for licensure to provide emergency medical services under the Emergency Medical Services Act; and

(2) "licensee" means a person that holds a license to provide emergency medical services pursuant to the Emergency Medical Services Act.

History: Laws 2014, ch. 47, § 2.

24-10B-6. Treatment authorized.

A. Notwithstanding the provisions of the Medical Practice Act [Chapter 61, Article 6 NMSA 1978], Sections 61-10-1 [repealed] through 61-10-22 NMSA 1978 or the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978], any person licensed by the bureau may render emergency medical services commensurate with his level of licensure, as medically indicated.

B. Individuals licensed pursuant to the provisions of the Medical Practice Act, Sections 61-10-1 [repealed] through 61-10-22 NMSA 1978 or the Nursing Practice Act are not required to be licensed under the Emergency Medical Services Act.

History: Laws 1983, ch. 190, § 6; 1993, ch. 161, § 6; 2003, ch. 243, § 6.

24-10B-7. Committees established.

A. The secretary shall appoint a statewide emergency medical services advisory committee to advise the bureau in carrying out the provisions of the Emergency Medical Services Act. The advisory committee shall include, at a minimum, representatives from the state medical society, the state emergency medical technicians' association, the state firefighters' association, the New Mexico ambulance association, the state nurses' association, the association of public safety communications organization/national emergency numbers association, the lead state agency for public safety and emergency preparedness, the state emergency services council, the New Mexico health and hospital systems association, the university of New Mexico health sciences center, the state fire chiefs' association, a consumer, emergency medical service regional offices and other interested provider and consumer groups as determined by the secretary. The advisory committee shall establish appropriate subcommittees, including a trauma advisory committee and an air transport advisory committee.

B. The joint organization on education committee shall be composed, at a minimum, of the director and medical director of the academy and each approved emergency medical services training program or their designee, the state emergency medical services medical director, the bureau chief or his designee, who shall serve without vote, each emergency medical services regional office training coordinator and one provider from the three highest levels of licensure, who are appointed by the secretary from a list proposed by the statewide emergency medical services advisory committee. The duties of the joint organization on education committee include:

(1) developing minimum curricula content for approved emergency medical services training programs;

(2) establishing minimum standards for approved emergency medical services training programs;

(3) reviewing and approving the applications of organizations seeking to become approved emergency medical services training programs; and

(4) developing minimum qualifications for and maintaining a list of instructors for each of the approved emergency medical services training programs.

C. The secretary shall appoint a medical direction committee to advise the bureau on matters relating to medical direction. The state emergency medical services medical director shall be a member of the committee and shall act as its chairman. The medical direction committee shall include, at a minimum, a physician representative experienced in pre-hospital medical care selected from a list proposed by the New Mexico chapter of the American college of emergency physicians, a physician representative from the academy, one physician from each of the emergency medical services geographic regions, one physician with pediatric emergency medicine expertise, one physician representing emergency medical dispatchers and one provider from the three highest

levels of licensure. Members shall be selected to represent both public and private interests. The duties of the medical direction committee include:

(1) reviewing the medical appropriateness of all rules proposed by the bureau;

(2) reviewing and approving the applications of providers for special skills authorizations;

(3) assisting in the development of rules pertaining to medical direction; and

(4) reviewing at least annually a list of skills, techniques and medications approved for use at each level of licensure that shall be approved by the secretary and issued by the bureau.

D. The committees created in this section are subject to the provisions of the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978], to the extent that funds are available for that purpose.

E. Any decision that the bureau proposes to make contrary to the recommendation of any committee created in this section shall be communicated in writing to that committee. Upon the request of that committee, the decision shall be submitted for reconsideration to the director of the public health division of the department and subsequently to the secretary. Any decision made pursuant to a request for reconsideration shall be communicated in writing by the department to the appropriate committee.

History: Laws 1983, ch. 190, § 7; 1993, ch. 161, § 8; 2003, ch. 243, § 7.

24-10B-8. Liability.

In any claim for civil damages arising out of the provision of emergency medical services by personnel described in Section 24-10B-5 NMSA 1978, those personnel shall be considered health care providers for purposes of the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978] if the claim is against a governmental entity or a public employee as defined by that act.

History: Laws 1983, ch. 190, § 8; 1993, ch. 161, § 9.

24-10B-9. Emergency first aid.

Nothing in the Emergency Medical Services Act shall prevent fire and rescue services, public safety organizations and other trained units or individuals from rendering emergency first aid to the public commensurate with their training. Nothing in the Emergency Medical Services Act shall be construed to supersede other statutory authority permitting the rendering of first aid.

History: Laws 1983, ch. 190, § 9; 1993, ch. 161, § 10; 2003, ch. 243, § 8.

24-10B-9.1. Emergency transportation.

Any person may be transported to an appropriate health care facility by an emergency medical technician, under medical direction, when the emergency medical technician makes a good faith judgment that the person is incapable of making an informed decision about his own safety or need for medical attention and is reasonably likely to suffer disability or death without the medical intervention available at such a facility.

History: Laws 1993, ch. 161, § 11; 2003, ch. 243, § 9.

24-10B-10. Enforcement.

The department may bring civil action in any district court to enforce any of the provisions of the Emergency Medical Services Act.

History: Laws 1983, ch. 190, § 10.

24-10B-11. Summoning emergency vehicle without cause; penalty.

Any person who willfully summons an ambulance or emergency response vehicle or reports that one is needed when that person knows that the ambulance or emergency response vehicle is not needed is guilty of a petty misdemeanor.

History: Laws 1983, ch. 190, § 11.

24-10B-12. Academy; duties.

The academy is designated as the lead emergency medical services training agency. Its duties include:

A. administering formal emergency medical services training conducted in New Mexico, other than training provided by other approved emergency medical services training programs;

B. furthering the knowledge of emergency medical services education;

C. securing a physician as its medical director to advise it in medical matters and to serve as liaison to the state emergency medical services medical director and the medical community as a whole;

D. supporting, promoting and conducting scholarly research regarding emergency medical services; and

E. reporting and publishing emergency medical services information.

History: Laws 1993, ch. 161, § 7; 2003, ch. 243, § 10.

24-10B-13. Certification of STEMI receiving and referring centers.

A. As used in this section, "STEMI" means ST segment elevation myocardial infarction.

B. In accordance with department rules, the department shall certify an acute care hospital as a STEMI receiving center or STEMI referring center if that hospital has been accredited as a STEMI receiving center or STEMI referring center by a nationally recognized organization that provides STEMI receiving or referring accreditation.

C. The department shall post information regarding certification on the department's website. The department shall coordinate with local and regional emergency medical services on the development and implementation of triage and transport plans for STEMI patients.

D. If a hospital loses its national accreditation as a STEMI receiving center or STEMI referring center, the secretary shall revoke the hospital's certification.

E. The secretary may adopt rules:

(1) relating to STEMI certification and revocation of certification by the department; and

(2) to assist and encourage STEMI receiving centers to enter into coordinated STEMI care agreements with STEMI referring centers and other health care facilities throughout the state to provide appropriate access to care for acute heart attack patients.

History: Laws 2013, ch. 6, § 1; 2019, ch. 28, § 1.

ARTICLE 10C
Cardiac Arrest Response

24-10C-1. Short title.

Sections 1 through 7 [24-10C-1 to 24-10C-7 NMSA 1978] of this act may be cited as the "Cardiac Arrest Response Act".

History: Laws 1999, ch. 94, § 1.

24-10C-2. Findings and purpose.

A. The legislature finds that:

(1) each year more than three hundred fifty thousand Americans die from out-of-hospital sudden cardiac arrest;

(2) the American heart association estimates that more than twenty thousand deaths could be prevented each year if early defibrillation were more widely available. In cardiac arrest the first several minutes are the most crucial time in which performing defibrillation can significantly improve chances for survival;

(3) the reality is that even in the best emergency medical services systems, emergency medical technicians or first responders may not always be able to arrive during that critical window of time; and

(4) virtually all communities in New Mexico have invested in 911 emergency response systems, emergency medical personnel and ambulance vehicles. However, many of them do not have enough defibrillators in their community [communities].

B. It is the purpose of the Cardiac Arrest Response Act to encourage greater acquisition, deployment and use of automated external defibrillators in communities across the state.

History: Laws 1999, ch. 94, § 2.

24-10C-3. Definitions.

As used in the Cardiac Arrest Response Act:

A. "automated external defibrillator" means a medical device heart monitor and defibrillator that:

(1) has received approval of its premarket modification filed pursuant to 21 U.S.C. 360(k), from the United States food and drug administration;

(2) is capable of recognizing cardiac arrest that will respond to defibrillation, ventricular fibrillation or rapid ventricular tachycardia, and is capable of determining whether defibrillation should be performed; and

(3) upon determining that defibrillation should be performed, automatically charges and is capable of delivering an electrical impulse to an individual's heart;

B. "automated external defibrillator program" means a program of trained targeted responders registered with the department;

C. "defibrillation" means the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm;

D. "department" means the department of health;

E. "good Samaritan" means a person who lacks automated external defibrillator training but who has access to an automated external defibrillator and provides emergency automated external defibrillator services to a person in need of defibrillation, provided that the good Samaritan:

(1) acts without willful, wanton or reckless behavior that is the cause of injury or death; and

(2) acts without compensation;

F. "person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture or any legal or commercial entity; and

G. "trained targeted responder" means a person trained in the use of an automated external defibrillator under emergency cardiac care guidelines.

History: Laws 1999, ch. 94, § 3; 2007, ch. 163, § 1; 2015, ch. 33, § 1.

24-10C-4. Protection of public safety.

A person that acquires an automated external defibrillator shall ensure that:

A. a trained targeted responder is designated to oversee all aspects of the automated external defibrillator program, including training, emergency medical services coordination, protocol approval and automated external defibrillator deployment strategies, and that the trained targeted responder provides overall quality assurance and reviews each case in which the automated external defibrillator is used by the program;

B. the trained targeted responders receive appropriate training in cardiopulmonary resuscitation and in the use of an automated external defibrillator by a nationally recognized course in cardiopulmonary response and automated external defibrillator use approved by the department or other training programs authorized by the department;

C. the defibrillator is maintained and tested according to the manufacturer's guidelines;

D. any person that renders emergency care or treatment on a person in cardiac arrest by using an automated external defibrillator activates the emergency medical system as soon as possible and reports any clinical use of the automated external defibrillator to the designated trained targeted responder;

E. the automated external defibrillator program is registered with the department; and

F. the local emergency medical services and local 911 agencies have been notified of the automated external defibrillator program.

History: Laws 1999, ch. 94, § 4; 2007, ch. 163, § 2; 2015, ch. 33, § 2.

24-10C-5. Authority.

A person may acquire an automated external defibrillator if the person has met all the requirements of Section 24-10C-4 NMSA 1978. Nothing in this section limits the right of a person to practice a health profession that the person is otherwise authorized to practice in accordance with the laws of New Mexico.

History: Laws 1999, ch. 94, § 5; 2007, ch. 163, § 3.

24-10C-6. Exemption.

Nothing in the Cardiac Arrest Response Act precludes a physician or a physician assistant, advanced practice registered nurse or certified nurse-midwife working within that person's scope of practice from prescribing an automated external defibrillator to a patient for use by the patient's caregiver on an individual patient, and the use does not require the individual to function in an approved program.

History: Laws 1999, ch. 94, § 6; 2007, ch. 163, § 4; 2015, ch. 116, § 11.

24-10C-7. Limited liability protections.

A. The following persons who render emergency care or treatment by the use of an automated external defibrillator pursuant to the provisions of the Cardiac Arrest Response Act shall not be subject to civil liability, provided that they have acted with reasonable care and in compliance with the requirements of that act:

(1) a trained targeted responder who provides supervisory services pursuant to the Cardiac Arrest Response Act;

(2) a person that provides training in cardiopulmonary resuscitation and use of automated external defibrillation;

(3) a person that acquires, provides or makes available to the public an automated external defibrillator pursuant to the Cardiac Arrest Response Act;

(4) the owner, manager or operator of the property or facility where the automated external defibrillator is located;

(5) a person that authorizes, directs or supervises the installation or placement of an automated external defibrillator; and

(6) the trained targeted responder.

B. A good Samaritan who renders emergency care or treatment by the use of an automated external defibrillator pursuant to the provisions of the Cardiac Arrest Response Act shall not be subject to civil liability; provided that the good Samaritan has acted without willful, wanton or reckless behavior that is the cause of injury or death and in compliance with the requirements of that act.

History: Laws 1999, ch. 94, § 7; 2007, ch. 163, § 5; 2015, ch. 33, § 3.

ARTICLE 10D
Sexual Assault Survivors Emergency Care

24-10D-1. Short title.

This act [24-10D-1 to 24-10D-5 NMSA 1978] may be cited as the "Sexual Assault Survivors Emergency Care Act".

History: Laws 2003, ch. 91, § 1.

24-10D-2. Definitions.

As used in the Sexual Assault Survivors Emergency Care Act:

A. "department" means the department of health;

B. "emergency care for sexual assault survivors" means medical examinations, procedures and services provided by a hospital to a sexual assault survivor following an alleged sexual assault;

C. "emergency contraception" means a drug approved by the federal food and drug administration that prevents pregnancy after sexual intercourse;

D. "hospital" means a facility providing emergency or urgent health care;

E. "medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards; published in peer-reviewed journals; and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology, such as the American college of obstetricians and gynecologists;

F. "sexual assault" means the crime of criminal sexual penetration; and

G. "sexual assault survivor" means a female who alleges or is alleged to have been sexually assaulted and who presents as a patient to a hospital.

History: Laws 2003, ch. 91, § 2.

24-10D-3. Emergency care for sexual assault survivors; standard of care.

A. A hospital that provides emergency care for sexual assault survivors shall:

(1) provide each sexual assault survivor with medically and factually accurate and objective written and oral information about emergency contraception;

(2) orally and in writing inform each sexual assault survivor of her option to be provided emergency contraception at the hospital; and

(3) provide emergency contraception at the hospital to each sexual assault survivor who requests it.

B. The provision of emergency contraception pills shall include the initial dose that the sexual assault survivor can take at the hospital as well as the subsequent dose that the sexual assault survivor may self-administer twelve hours following the initial dose.

History: Laws 2003, ch. 91, § 3.

24-10D-4. Training.

No later than September 30, 2003:

A. a hospital shall ensure that all personnel who provide care to sexual assault survivors are trained to provide medically and factually accurate and objective information about emergency contraception; and

B. the department shall adopt rules regulating the training to be provided by hospitals pursuant to the Sexual Assault Survivors Emergency Care Act to personnel who provide emergency care for sexual assault survivors.

History: Laws 2003, ch. 91, § 4.

24-10D-5. Enforcement; administrative fines.

A. Complaints of failure to provide services required by the Sexual Assault Survivors Emergency Care Act may be filed with the department.

B. The department shall immediately investigate every complaint it receives regarding failure of a hospital to provide services required by the Sexual Assault Survivors Emergency Care Act to determine the action to be taken to satisfy the complaint.

C. The department shall compile all complaints it receives regarding failure to provide services required by the Sexual Assault Survivors Emergency Care Act and shall retain the complaints for at least ten years so that they can be analyzed for patterns of failure to provide services pursuant to that act.

D. If the department determines that a hospital has failed to provide the services required in the Sexual Assault Survivors Emergency Care Act, the department shall:

(1) issue a written warning to the hospital upon receipt of a complaint that the hospital is not providing the services required by the Sexual Assault Survivors Emergency Care Act; and

(2) based on the department's investigation of the first complaint, require the hospital to correct the deficiency leading to the complaint.

E. If after the issuance of a written warning to the hospital pursuant to Subsection D of this section, the department finds that the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the department shall, for a second through fifth complaint, impose on the hospital a fine of one thousand dollars ($1,000):

(1) per sexual assault survivor who is found by the department to have been denied medically and factually accurate and objective information about emergency contraception or who is not offered or provided emergency contraception; or

(2) per month from the date of the complaint alleging noncompliance until the hospital provides training pursuant to the rules of the department.

F. For the sixth and subsequent complaint against the same hospital if the department finds the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the department shall impose an intermediate sanction pursuant to Section 24-1-5.2 NMSA 1978 or suspend or revoke the license of the hospital issued pursuant to the Public Health Act [Chapter 24, Article 1 NMSA 1978].

History: Laws 2003, ch. 91, § 5.

ARTICLE 10E
Trauma System Fund Authority

24-10E-1. Short title.

This act [24-10E-1 to 24-10E-7 NMSA 1978] may be cited as the "Trauma System Fund Authority Act".

History: Laws 2006, ch. 13, § 1.

24-10E-2. Purpose of act.

The purpose of the Trauma System Fund Authority Act is to provide funding to sustain existing trauma centers, support the development of new trauma centers and develop a statewide trauma system.

History: Laws 2006, ch. 13, § 2.

24-10E-3. Definitions.

As used in the Trauma System Fund Authority Act:

A. "authority" means the trauma system fund authority;

B. "department" means the department of health;

C. "fund" means the trauma system fund;

D. "secretary" means the secretary of health; and

E. "statewide trauma system" means a coordinated continuum of care that includes injury prevention, emergency medical, acute care hospital and rehabilitative services and that is subject to accountability and system improvement.

History: Laws 2006, ch. 13, § 3.

24-10E-4. Trauma system fund authority created; membership.

A. The "trauma system fund authority" is created. The authority is administratively attached to the department.

B. The authority shall consist of at least nine members, all of whom shall be appointed by and serve at the pleasure of the governor. The membership of the authority shall include the following:

(1) the secretary or the secretary's designee;

(2) representation from the medical specialty of trauma physicians;

(3) at least one member of a statewide organization representing physicians in New Mexico;

(4) at least one member representing emergency and trauma nursing practice;

(5) at least one member of a statewide organization representing hospitals and health systems in New Mexico;

(6) at least one member of a statewide organization representing injury prevention;

(7) the chair of the statewide emergency medical services advisory committee;

(8) the chair of the trauma advisory committee; and

(9) at least one member of a statewide organization representing rehabilitation services.

C. Authority members shall elect a chair and other officers as the authority deems appropriate.

D. The authority shall meet regularly at the call of the chair.

History: Laws 2006, ch. 13, § 4.

24-10E-5. Duties.

The authority shall:

A. develop criteria by which distribution of funds to existing trauma centers and potential new centers will occur;

B. receive applications and determine and monitor the actual distribution of money from the fund that will support the development of a statewide system of trauma care;

C. oversee the department's administration of the fund and the development of a trauma system; and

D. report annually to the interim legislative health and human services committee and the legislative finance committee.

History: Laws 2006, ch. 13, § 5.

24-10E-6. Trauma system fund created; funding.

A. The "trauma system fund" is created in the state treasury. The fund shall consist of money appropriated and transferred to the fund, money received by the authority from any public or private source and tax revenues distributed to the fund by law. Interest earned on investment of the fund shall be credited to the fund. Disbursements from the fund shall be made upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of health or the secretary's authorized representative. Money in the fund shall not revert at the end of any fiscal year.

B. Money in the fund is appropriated to the department for the purpose of making distributions approved by the authority and for administering the Trauma System Fund Authority Act; provided that no more than five percent of the fund may be used by the department for administrative costs, including monitoring, trauma system development and providing technical assistance.

History: Laws 2006, ch. 13, § 6.

24-10E-7. Rules.

The department shall promulgate rules to carry out the provisions of the Trauma System Fund Authority Act.

History: Laws 2006, ch. 13, § 7.

ARTICLE 11
Medical Investigations

24-11-1. Board of medical investigators; creation; membership; compensation.

There is created the "board of medical investigators", consisting of the dean of the university of New Mexico school of medicine, the secretary of health, the chief of the New Mexico state police, the chair of the board of funeral services and the secretary of Indian affairs. The members of the board of medical investigators shall receive no compensation for their services as board members other than as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

History: 1953 Comp., § 12-17-1, enacted by Laws 1971, ch. 112, § 1; and recompiled as 1953 Comp., § 12-29-1, by Laws 1972, ch. 51, § 9; 1973, ch. 286, § 1; 1977, ch. 253, § 38; 1981, ch. 96, § 1; 2003, ch. 191, § 1; 2012, ch. 48, § 2.

24-11-2. Meetings; duties.

A. The board of medical investigations [investigators] shall meet at least annually and as often as necessary to conduct the business of the board. Additional meetings may be called by the chairman or by a majority of the members of the board.

B. At the first annual meeting of the board, the members shall elect one of their number as chairman.

C. The board of medical investigations [investigators] shall formulate broad policy for the operation of the office of the state medical investigator and the offices of the district medical investigators.

D. The board of medical investigations [investigators] shall employ and fix the compensation of a qualified state medical investigator who shall be assigned as an employee of the university of New Mexico school of medicine.

History: 1953 Comp., § 12-17-2, enacted by Laws 1971, ch. 112, § 2; recompiled as 1953 Comp., § 12-29-2, by Laws 1972, ch. 51, § 9; 1973, ch. 286, § 2.

24-11-3. State medical investigator; qualifications; duties; office.

A. The state medical investigator shall be a physician licensed to practice in New Mexico. Insofar as practicable, the medical investigator shall be trained in the fields of pathology and forensic medicine.

B. The state medical investigator shall maintain his office at the school of medicine at the university of New Mexico.

C. The state medical investigator shall appoint district medical investigators and where necessary deputy medical investigators who shall serve at his pleasure. The state medical investigator may assign deputy medical investigators to districts to work under the supervision of a district medical investigator. The district medical investigator shall be a licensed physician. When deemed necessary by the state medical investigator, he may direct a deputy or district medical examiner to enter another district for the purpose of carrying out medical investigations.

D. Any district created by the state medical investigator to be staffed by a district medical investigator shall be co-extensive with one or more counties.

E. The state medical investigator may enter into agreements for services to be performed by persons in the course of medical investigations.

F. The state medical investigator shall, subject to the approval of the board of medical investigations, promulgate rules and regulations for the proper investigation of deaths occurring within this state.

G. The state medical investigator shall maintain records of the deaths occurring within this state which are investigated by either state or district medical investigators.

H. In addition to other duties prescribed in this section, the state medical investigator shall also serve as the district medical investigator for Bernalillo county.

I. Funds for the operation of the state and district medical investigators' offices shall be appropriated to and administered by the university of New Mexico school of medicine.

History: 1953 Comp., § 12-17-3, enacted by Laws 1971, ch. 112, § 3; recompiled as 1953 Comp., § 12-29-3, by Laws 1972, ch. 51, § 9; 1973, ch. 286, § 3.

24-11-4. [References to coroner.]

As used in the New Mexico Statutes Annotated, 1978 Compilation, "coroner" means the district medical investigator.

History: 1953 Comp., § 15-43-43.1, enacted by Laws 1971, ch. 112, § 10.

24-11-5. Reports of violent death.

When any person comes to a sudden, violent or untimely death or is found dead and the cause of death is unknown, anyone who becomes aware of the death shall report it immediately to law enforcement authorities or the office of the state or district medical investigator. The public official so notified, shall in turn notify either, or both, the appropriate law enforcement authorities or the office of the state or district medical investigator. The state or district medical investigator, or a deputy medical investigator under his direction, shall, without delay, view and take legal custody of the body.

History: 1953 Comp., § 15-43-44, enacted by Laws 1961, ch. 91, § 2; 1971, ch. 112, § 4; 1973, ch. 286, § 4; 1975, ch. 7, § 1.

24-11-6. Death certificate; release of body; reports.

A. If, after viewing the body, notifying the law enforcement agency with jurisdiction and making an investigation, the state or district medical investigator is satisfied that the death was not caused by criminal act or omission and that there are no suspicious circumstances about the death, he shall execute a death certificate in the form required by law. He shall also execute a certificate on a form prescribed by the health and social services department [department of health], authorizing release of the body to the funeral director for burial. In those cases in which the investigation is performed by a deputy medical investigator, if, after viewing the body, notifying the law enforcement agency with jurisdiction and making an investigation, he is satisfied that the death was not caused by criminal act or omission and that there are no suspicious circumstances about the death, he shall report this finding to the state or district medical investigator

under whose direction he is working. Upon receipt of a report from a deputy medical investigator under this subsection, the state or district medical investigator may execute a death certificate and a certificate authorizing release of the body for burial.

B. In those cases where the death resulted from a motor vehicle accident on a public highway, and the state, district or deputy medical investigator performs or causes to be performed a test or tests to determine the alcoholic content of the deceased's blood, a copy of the report of this test shall be sent to the planning division of the state highway department for the department's use only for statistical purposes. The copy of the report sent to the planning division of the state highway department of the results shall not contain any identification of the deceased and shall not be subject to judicial process.

History: 1953 Comp., § 15-43-45, enacted by Laws 1961, ch. 91, § 3; 1969, ch. 36, § 1; 1971, ch. 112, § 5; 1973, ch. 286, § 5; 1975, ch. 7, § 2.

24-11-6.1. Deceased members of Indian nations, tribes or pueblos; consultation and certification required.

A. The state medical investigator shall make reasonable efforts to determine if a deceased person is a member of a federally recognized Indian nation, tribe or pueblo. If a deceased person has been determined to be a member of a federally recognized Indian nation, tribe or pueblo, the state medical investigator shall use all due diligence to avoid an autopsy except when legally required due to possible criminal acts or omissions, an obscure cause of death or other reasons or pursuant to consent given according to the provisions of Section 24-12-4 NMSA 1978. The state medical investigator shall use the least invasive means possible to satisfy the investigator's legal duties in conducting an autopsy.

B. If the state medical investigator determines that an autopsy cannot be avoided, the investigator shall attempt to provide advance notice of the autopsy to the surviving spouse or next of kin, or to the Indian nation, tribe or pueblo of the deceased. The state medical investigator shall provide documentation concerning the autopsy upon request of the surviving spouse or next of kin, or if none is identified, to the Indian nation, tribe or pueblo of which the deceased was a member.

C. If requested by the surviving spouse or the next of kin, or if none is identified, by the Indian nation, tribe or pueblo through an official representative designated pursuant to Subsection E of this section, the state medical investigator shall permit a law enforcement officer of the Indian nation, tribe or pueblo of the deceased to be present during the autopsy. The law enforcement officer attending the autopsy may not interfere with the autopsy procedure and shall follow the health regulations governing autopsy procedures.

D. After any legally required autopsy or postmortem examination has been conducted, the state medical investigator shall use all due diligence to consult with the

surviving spouse or next of kin of the deceased regarding the disposition of all of the deceased's remains. Unless other treatment of the remains is required by law, the state medical investigator shall replace all body parts and, if requested, shall provide written certification to the surviving spouse or next of kin of the deceased that the investigator has replaced all body parts.

E. The state medical investigator shall request that each Indian nation, tribe and pueblo located in New Mexico designate, and keep current the designation of, an official representative that the state medical investigator shall contact when it is necessary to contact a tribal representative regarding an autopsy or the disposition of the remains of a deceased member of the Indian nation, tribe or pueblo.

History: Laws 2003, ch. 191, § 2; 2005, ch. 263, § 1.

24-11-7. Examination; autopsy; inquest.

If the deceased is unidentified, the state, district or deputy medical investigator may order the body fingerprinted and photographed. When the state, district or deputy medical investigator suspects a death was caused by a criminal act or omission or if the cause of death is obscure, he shall order an autopsy performed by a qualified pathologist certified by the state board of medical examiners who shall record every fact found in the examination tending to show the identity and condition of the body and the time, manner and cause of death. The pathologist shall sign the report under oath and deliver it to the state, district or deputy medical investigator within a reasonable time. The state, district or deputy medical investigator may take the testimony of the pathologist and any other persons and this testimony, combined with the written report of the pathologist, constitutes an inquest.

History: 1953 Comp., § 15-43-46, enacted by Laws 1961, ch. 91, § 4; 1971, ch. 112, § 6; 1973, ch. 286, § 6.

24-11-8. Reports to district attorney.

The state or district medical investigator shall promptly report his findings, or the findings of a deputy medical investigator that has performed an investigation under his direction, to the district attorney in each death investigated. Upon request of the district attorney, the state or district medical investigator shall send a complete record of the medical investigation in any case, including a transcript of the testimony of witnesses examined at any inquest.

History: 1953 Comp., § 15-43-47, enacted by Laws 1961, ch. 91, § 5; 1971, ch. 112, § 7; 1973, ch. 286, § 7.

24-11-9. Subpoena; oath.

The state, district or deputy medical investigator may administer oaths and may issue a subpoena to compel the attendance and production of evidence by any necessary witness and the subpoena may be enforced in the district court. Any subpoena shall be served without cost by the sheriff or any deputy or by any member of the New Mexico state police.

History: 1953 Comp., § 15-43-48, enacted by Laws 1961, ch. 91, § 6; 1971, ch. 112, § 8; 1973, ch. 286, § 8.

24-11-10. Penalties.

A. It is unlawful to:

(1) willfully and without good cause neglect or refuse to report a death to law enforcement authorities or the office of the state or district medical investigator as required by law; or

(2) willfully and unnecessarily touch, remove or disturb any dead body required by law to be reported to the state or district medical investigator, or any article on or near the body or disturb its surroundings until authority is granted by the state, district or deputy medical investigator.

B. Any person violating this section is guilty of a petty misdemeanor.

History: 1953 Comp., § 15-43-50, enacted by Laws 1961, ch. 91, § 8; 1971, ch. 112, § 9; 1973, ch. 286, § 9; 1975, ch. 7, § 3.

ARTICLE 12
Disposition of Dead Bodies

24-12-1. Notification of legal next of kin of decedent; authorization of person designated on record of emergency data form to direct burial; unclaimed decedents.

A. As used in this section:

(1) "due diligence" means the reasonable steps taken to satisfy the legal requirement relating to the disposition of dead bodies, including attempts to identify the body and locate legal next of kin; and

(2) "legal next of kin" means the following persons in the order listed:

(a) the surviving spouse;

(b) a majority of the surviving adult children of the decedent;

(c) the surviving parents of the decedent;

(d) a majority of the surviving siblings of the decedent;

(e) the adult person of the next degree of kinship in the order named by New Mexico law to inherit the estate of the decedent; or

(f) an adult who has exhibited special care and concern for the decedent and is aware of the decedent's views and desires regarding the disposition of the decedent's body and is willing and able to make a decision about the disposition of the decedent's body.

B. State, county, municipal officials or other person having charge or control of the body of a decedent shall use due diligence to notify the legal next of kin or other claimant of the decedent.

C. If the decedent died while serving in any branch of the United States armed forces, the United States reserve forces or the national guard, during any period of duty when the secretary of the military service concerned can provide for the recovery, care and disposition of remains, and the decedent completed a United States department of defense record of emergency data form or its successor form, the authority to direct the burial of the decedent or to provide other funeral and disposition arrangements for the decedent devolves on the person designated by the decedent pursuant to that form.

D. If no claimant is found who will assume the cost of burial, the official having charge or control of the decedent shall notify the county, stating, when possible, the name, age, sex, legal next of kin and cause of death of the deceased and any other information obtained that the county could use to conduct due diligence. The county may perform additional due diligence if reasonably determined necessary.

E. If reasonable opportunity has been afforded to the legal next of kin and if no other claimant has been found, the decedent may be deemed unclaimed and the legal next of kin deemed to have waived the right to take possession of the body. Unless the medical investigator retains the body in accordance with Section 24-12-2 NMSA 1978, the county shall authorize disposition of the body. As used in this subsection, "reasonable opportunity" means fourteen days after the legal next of kin has been notified at the legal next of kin's last known addresses.

F. The body shall be embalmed, if required, and buried or cremated according to rules of the agency having jurisdiction. After the exercise of due diligence required in Subsection B of this section, the medical investigator shall be provided material data demonstrating due diligence and the fact that no claimant has been found. When the medical investigator has determined that due diligence has been exercised, that reasonable opportunity has been afforded to legal next of kin to claim the body and that

the body has not been claimed, the medical investigator shall determine that the remains are unclaimed. In no case shall an unclaimed body be disposed of in less than two weeks from the date of the discovery of the body.

History: Laws 1941, ch. 148, § 1; 1941 Comp., § 71-501; 1953 Comp., § 12-7-1; reenacted by Laws 1973, ch. 354, § 1; 1977, ch. 204, § 1; 1978 Comp., § 24-12-1; 1999, ch. 241, § 1; 2011, ch. 22, § 1; 2023, ch. 162, § 1.

24-12-2. Authority of the office of the state medical investigator; disposition of unclaimed body; transmission of records of institution.

A. Upon the determination that a body is unclaimed, the medical investigator shall retain the body for use only for medical education or shall certify that the body is unnecessary or unsuited for medical education and release it to the state, county or municipal officials having charge or control of the body for burial. The state, county, municipal officials or other person having charge or control of the body of a decedent shall have the body removed for disposition within three weeks from the date on which the medical investigator notified the appropriate entity.

B. If the unclaimed body is retained for use in medical education, the facility or person receiving the body for that use shall pay the costs of preservation and transportation of the body and shall keep a permanent record of bodies received.

C. If a decedent was an inmate of a public institution, the institution shall transmit, upon request of the medical investigator, a brief medical history of the person for purposes of identification and permanent record. The records shall be open to inspection by any state or county official or district attorney.

History: Laws 1941, ch. 148, §§ 3 to 5; 1941 Comp., §§ 71-503 to 71-505; 1953 Comp., § 12-7-2, reenacted by Laws 1973, ch. 354, § 2; 1977, ch. 204, § 2; 1978 Comp., § 24-12-2; 1999, ch. 241, § 2; 2023, ch. 162, § 2.

24-12-3. Penalties.

A. A person who conducts a post-mortem examination on an unclaimed body without express permission of the medical investigator is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978.

B. A person who unlawfully disposes of, uses or sells an unclaimed body is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

History: Laws 1941, ch. 148, §§ 2, 4; 1941 Comp., §§ 71-502, 71-504; 1953 Comp., § 12-7-4, reenacted by Laws 1973, ch. 354, § 3; 1978 Comp., § 24-12-3; 2023, ch. 162, § 3.

24-12-4. Post-mortem examinations and autopsies; consent required.

A. An autopsy or post-mortem examination may be performed on the body of a decedent by a physician or surgeon whenever consent to the procedure has been given by:

(1) written authorization signed by the decedent during the person's lifetime;

(2) authorization of a person or on behalf of any person whom the decedent designated in writing during the person's lifetime to take charge of the decedent's body for burial or other purposes;

(3) authorization of the decedent's surviving spouse;

(4) authorization of an adult child, parent or adult brother or sister of the decedent if there is no surviving spouse or if the surviving spouse is unavailable, incompetent or has not claimed the body for burial after notification of the death of the decedent;

(5) authorization of any other relative of the decedent if none of the persons enumerated in Paragraph (4) of this subsection is available or competent to give authorization; or

(6) authorization of the public official, agency or person having custody of the body for burial if none of the persons enumerated in Paragraphs (2) through (5) of this subsection is available or competent to give authorization.

B. An autopsy or post-mortem examination shall not be performed under authorization given pursuant to the provisions of Paragraph (4) of Subsection A of this section by any one of the persons enumerated if, before the procedure is performed, any one of the other persons enumerated objects in writing to the physician or surgeon by whom the procedure is to be performed.

C. An autopsy or post-mortem examination may be performed by a pathologist at the written direction of the district attorney or the district attorney's authorized representative in any case in which the district attorney is conducting a criminal investigation.

D. An autopsy or post-mortem examination may be performed by a pathologist at the direction of the state, district or deputy medical investigator when the state, district

or deputy medical investigator suspects the death was caused by a criminal act or omission or if the cause of death is obscure.

E. For purposes of this section, "autopsy" means a post-mortem dissection of a dead human body in order to determine the cause, seat or nature of disease or injury and includes the retention of tissues customarily removed during the course of autopsy for evidentiary, identification, diagnosis, scientific or therapeutic purposes.

History: 1953 Comp., § 12-7-9, enacted by Laws 1965, ch. 86, § 1; reenacted by 1973, ch. 354, § 4; 1978 Comp., § 24-12-4; 1993, ch. 129, § 1; 2023, ch. 162, § 4.

ARTICLE 12A
Cremations

24-12A-1. Right to authorize cremation; definitions.

A. An adult may authorize the adult's own cremation and the lawful disposition of the cremated remains by:

(1) stating the desire to be cremated in a written statement that is signed by the adult and notarized or witnessed by two persons; or

(2) including an express statement in the will indicating that the testator desired that the remains be cremated upon death.

B. A personal representative acting pursuant to a will or the provisions of Chapter 45, Article 3 NMSA 1978 or a funeral service establishment, a direct disposition establishment or a crematory shall comply with a statement made in conformance with the provisions of Subsection A of this section. The statement is authorization to the personal representative, funeral establishment, direct disposition establishment or crematory that the remains of the decedent are to be cremated. Statements dated prior to April 5, 1993 are to be given effect if they meet the requirements of Subsection A of this section.

C. A personal representative, funeral service establishment, direct disposition establishment or crematory acting in reliance upon a document executed pursuant to the provisions of this section, who has no actual notice of revocation or contrary indication, is presumed to be acting in good faith.

D. A funeral service establishment, direct disposition establishment, crematory or employee of a funeral establishment, direct disposition establishment or crematory or other person that relies in good faith on a statement written pursuant to this section shall not be subject to liability for cremating the remains in accordance with the express instructions of a decedent. The written document is a complete defense to a cause of

action by any person against any other person acting in accordance with the instructions of the decedent.

E. As used in this section:

(1) "cremate" means to reduce a dead human body by direct flame to a residue that may include bone fragments; and

(2) "direct disposition establishment" means an office, premises or place of business that provides for the disposition of a dead human body as quickly as possible, without a funeral, graveside service, committal service or memorial service, whether public or private, and without embalming of the body unless embalming is required by the place of disposition.

History: Laws 1993, ch. 200, § 1; 2023, ch. 162, § 5.

24-12A-2. No written instructions; priority of others to decide disposition.

A. Except as provided in Subsection B of this section, if a decedent has left no written instructions regarding the disposition of the decedent's remains, the following persons are legal next of kin, in the order listed, and shall determine the means of disposition, not to be limited to cremation, of the remains of the decedent:

(1) the surviving spouse;

(2) a majority of the surviving adult children of the decedent;

(3) the surviving parents of the decedent;

(4) a majority of the surviving siblings of the decedent;

(5) the adult person of the next degree of kinship in the order named by New Mexico law to inherit the estate of the decedent; or

(6) an adult who has exhibited special care and concern for the decedent and is aware of the decedent's views and desires regarding the disposition of the decedent's body and who is willing and able to make a decision about the disposition of the decedent's body.

B. If a decedent left no written instructions regarding the disposition of the decedent's remains, died while serving in any branch of the United States armed forces, the United States reserve forces or the national guard and completed a United States department of defense record of emergency data form or its successor form, the person authorized by the decedent to determine the means of disposition on a United States

department of defense record of emergency data form shall determine the means of disposition, not to be limited to cremation.

C. The state, county, municipality or other person having charge or control of the body of a decedent shall notify or attempt to notify the legal next of kin.

History: Laws 1993, ch. 200, § 2; 1995, ch. 17, § 1; 2011, ch. 22, § 2; 2023, ch. 162, § 6.

24-12A-3. Unclaimed bodies; cremation permitted.

An unclaimed body, the disposition of which is the responsibility of the county pursuant to the provisions of Chapter 24, Article 13 NMSA 1978, may be cremated upon the order of the county official responsible for ensuring the disposition of the body or upon the order of any other government official authorized to order the cremation. Absent a showing of bad faith or malicious intent, the official ordering the cremation and the person or establishment carrying out the cremation shall be immune from liability related to the cremation.

History: 1978 Comp., § 24-12A-3, enacted by Laws 1999, ch. 241, § 3; 2023, ch. 162, § 7.

ARTICLE 13
Burial of Indigents

24-13-1. Burial or cremation of unclaimed decedents.

For the purposes of Chapter 24, Article 13 NMSA 1978, a dead body that has not been claimed by a friend, relative or other interested person assuming the responsibility for and expense of disposition shall be considered an unclaimed decedent. It is the duty of each county in this state to authorize interment or cremation of an unclaimed decedent. The county shall ensure that the body is buried or cremated no later than thirty days after a determination has been made that the body has not been claimed, but no less than fourteen days after death or discovery of the body. If the body is cremated, the county shall ensure that the cremated remains are retained and stored for at least two years, or one year for eligible veterans who qualify for veteran burial benefits, in a manner that allows for identification of the remains. After the expiration of two years, or one year for eligible veterans who qualify for veteran burial benefits, the cremated remains may be disposed of; provided the county retains a record of the place and manner of disposition for not less than five years after disposition.

History: Laws 1939, ch. 224, § 1; 1941 Comp., § 73-204; 1953 Comp., § 13-2-4; 1978 Comp., § 24-13-1; Laws 1999, ch. 241, § 4; 2023, ch. 162, § 8.

24-13-2. Persons deemed indigent.

A decedent shall be considered to be an indigent for purposes of Chapter 24, Article 13 NMSA 1978 if the decedent's estate is insufficient to cover the cost of burial or cremation or if the decedent's body is unclaimed.

History: Laws 1939, ch. 224, § 2; 1941 Comp., § 73-205; 1953 Comp., § 13-2-5; 1978 Comp., § 24-13-2; Laws 1999, ch. 241, §; 2023, ch. 162, § 9.

24-13-3. Expenses for burial or cremation.

If the unclaimed decedent had known assets or property of sufficient value to defray the expenses of cremation or burial, invoices for the expenses shall be forwarded to the executor of the estate of the decedent, and such person shall pay the expenses out of the decedent's estate. To the extent that the decedent is unclaimed and has no estate, the burial or cremation expenses shall be borne by the county of residence of the decedent. If the county of residence of the decedent is not known, the burial or cremation expenses shall be borne by the county in which the decedent was found. The burial or cremation expenses may be paid by the county out of the general fund or the health care assistance fund in the amount of one thousand dollars ($1,000) for the burial or cremation of the unclaimed decedent.

History: Laws 1939, ch. 224, § 3; 1941 Comp., § 73-206; 1953 Comp., § 13-2-6; Laws 1957, ch. 123, § 1; 1959, ch. 59, § 1; 1978 Comp., § 24-13-3; 1987, ch. 274, § 1; 1991, ch. 6, § 1; 1999, ch. 241, § 6; 2001, ch. 307, § 1; 2023, ch. 162, § 10.

24-13-4. Burial after investigation; cost of opening and closing grave.

The county after proper investigation shall cause an unclaimed decedent to be decently interred or cremated. The cost to be paid by the county of opening and closing a grave shall not exceed one thousand dollars ($1,000), which sum shall be in addition to the sums enumerated in Section 24-13-3 NMSA 1978.

History: Laws 1939, ch. 224, § 4; 1941 Comp., § 73-207; 1953 Comp., § 13-2-7; Laws 1957, ch. 123, § 2; 1978 Comp., § 24-13-4; 1997, ch. 116, § 1; 1999, ch. 241, § 7; 2023, ch. 162, § 11.

24-13-5. Payment of burial or cremation expenses; commissioners' liability.

The board of county commissioners of any county within this state may authorize payment for the burial or cremation of an unclaimed decedent, as defined in Section 24-13-1 NMSA 1978. All available assets of the deceased may be used to reimburse the county for the cost of burial or cremation. Should the county be required to pay expenses for burial or cremation of an unclaimed decedent who has left an estate, the estate shall reimburse the county for those expenses. The county commissioners may

be liable officially to the county they represent in double the amount they have paid toward the burial or cremation of a person other than as authorized by this section.

History: Laws 1939, ch. 224, § 5; 1941 Comp., § 73-208; 1953 Comp., § 13-2-8; 1978 Comp., § 24-13-5; Laws 1999, ch. 241, § 8; 2023, ch. 162, § 12.

24-13-6. Money from relatives; duty of funeral director.

Should a funeral director or other person allowed by law to conduct the business of a funeral director accept money from the relatives or friends of a decedent whom the county has determined to be an unclaimed decedent, the funeral director shall immediately notify the county of the payment or offer for payment, and the county shall not pay for the burial or cremation involved, or, if the county has already paid for the burial or cremation, the funeral director shall immediately refund the money paid to the funeral director by the county for the burial or cremation.

History: Laws 1939, ch. 224, § 6; 1941 Comp., § 73-209; 1953 Comp., § 13-2-9; 1978 Comp., § 24-13-6; Laws 1999, ch. 241, § 9; 2023, ch. 162, § 13.

24-13-7. Failure to notify; funeral director's liability.

If a funeral director or other person authorized by law to conduct the business of a funeral director receives or contracts to receive any money or thing of value from relatives or friends of an unclaimed decedent whose burial or cremation expenses are paid or to be paid by the county and fails to notify the county of that fact, the funeral director or other person authorized by law to conduct the business of a funeral director shall be liable to the county in an amount double the amount paid or to be paid by the county.

History: Laws 1939, ch. 224, § 7; 1941 Comp., § 73-211; 1953 Comp., § 13-2-11; 1978 Comp., § 24-13-7; Laws 1999, ch. 241, § 10; 2023, ch. 162, § 14.

24-13-8. [District attorneys to enforce burial act.]

The various district attorneys of this state are hereby expressly empowered and directed to enforce the provisions of this act [24-13-1 to 24-13-8 NMSA 1978] on behalf of the various counties which they represent.

History: Laws 1939, ch. 224, § 8; 1941 Comp., § 73-211; 1953 Comp., § 13-2-11.

ARTICLE 14
Vital Statistics

24-14-1. Short title.

Chapter 24, Article 14 NMSA 1978 may be cited as the "Vital Statistics Act".

History: 1953 Comp., § 12-4-23, enacted by Laws 1961, ch. 44, § 1; 2013, ch. 183, § 1.

24-14-2. Definitions.

As used in the Vital Statistics Act:

A. "vital statistics" means the data derived from certificates and reports of birth, death, spontaneous fetal death and induced abortion and related reports;

B. "system of vital statistics" includes the registration, collection, preservation, amendment and certification of vital records and related activities, including the tabulation, analysis and publication of statistical data derived from these records;

C. "filing" means the presentation of a certificate, report or other record of a birth, death, spontaneous fetal death or adoption for registration by the bureau;

D. "registration" means the acceptance by the bureau and the incorporation in its official records of certificates, reports or other records provided for in the Vital Statistics Act of births, deaths, spontaneous fetal deaths, adoptions and legitimations;

E. "live birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which after the expulsion or extraction breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;

F. "spontaneous fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, results in other than a live birth and that is not an induced abortion; and death is indicated by the fact that, after the expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles;

G. "dead body" means a human body, or parts of such body or bones thereof other than skeletal remains that can be classified as artifacts, dead within the meaning of Section 12-2-4 NMSA 1978;

H. "final disposition" means the burial, interment, cremation, entombment, pulverization or other authorized disposition of a dead body or fetus;

I. "department" means the department of health;

J. "court" means a court of competent jurisdiction;

K. "state registrar" means the designated employee of the bureau;

L. "vital records" means certificates of birth and death;

M. "induced abortion" means the purposeful interruption of pregnancy with the intention other than to produce a live-born infant;

N. "physician" means a person authorized or licensed to practice medicine or osteopathy pursuant to the laws of this state;

O. "institution" means any establishment, public or private:

(1) that provides in-patient medical, surgical or diagnostic care or treatment;

(2) that provides nursing, custodial or domiciliary care; or

(3) to which persons are committed by law; and

P. "bureau" means the vital records and health statistics bureau of the department.

History: 1953 Comp., § 12-4-24, enacted by Laws 1961, ch. 44, § 2; 1973, ch. 264, § 1; 1977, ch. 206, § 1; 1977, ch. 253, § 26; 1981, ch. 309, § 1; 2009, ch. 215, § 10.

24-14-3. Vital records and health statistics bureau; state system.

There is established in the department a "vital records and health statistics bureau" for the purpose of installing, maintaining and operating a system of vital statistics throughout this state and carrying out all regulations relating to vital records and health statistics established by the department.

History: 1953 Comp., § 12-4-25, enacted by Laws 1961, ch. 44, § 3; 1973, ch. 264, § 2; 1977, ch. 253, § 27; 1981, ch. 309, § 2; 2009, ch. 215, § 11.

24-14-4. State registrar; appointment.

The secretary of the department shall appoint the state registrar in accordance with the provisions of the Personnel Act [Chapter 10, Article 9 NMSA 1978].

History: 1953 Comp., § 12-4-26, enacted by Laws 1961, ch. 44, § 4; 1973, ch. 264, § 3; 2009, ch. 215, § 12.

24-14-5. Duties of state registrar.

A. The state registrar shall:

(1) administer and enforce the Vital Statistics Act and regulations issued pursuant to it and issue instructions for the efficient administration of the system of vital records and health statistics;

(2) direct and supervise the system of vital records and health statistics and be custodian of its records;

(3) direct, supervise and control the activities of all public employees, other than hospital employees, when they are engaged in activities pertaining to the operation of the system of vital records and health statistics;

(4) prescribe, with the approval of the department and after consultation with medical records professionals in the state, furnish and distribute such forms as are required by the Vital Statistics Act;

(5) prepare and publish reports of vital records and health statistics of this state and such other reports as may be required by the department;

(6) conduct training programs to promote uniformity of policy and procedures throughout the state; and

(7) provide to local health agencies copies of or data derived from certificates and reports required under the Vital Statistics Act as determined necessary for local health planning and program activities. The copies or data shall remain the property of the bureau, and the uses that may be made of them shall be prescribed by the state registrar.

B. The state registrar may establish or designate offices in the state to aid in the efficient administration of the system of vital records and health statistics and may delegate such functions and duties vested in the state registrar to employees of the bureau and to employees of any office of the state or political subdivision designated to aid in administering the Vital Statistics Act.

History: 1953 Comp., § 12-4-27, enacted by Laws 1961, ch. 44, § 5; 1973, ch. 264, § 4; 1977, ch. 253, § 28; 1981, ch. 309, § 3; 2009, ch. 215, § 13.

24-14-6. Repealed.

24-14-7. Appointment and removal of local registrars.

The state registrar:

A. may appoint local registrars in order to carry out the provisions of the Vital Statistics Act; and

B. may remove local registrars for reasonable cause.

History: 1953 Comp., § 12-4-29, enacted by Laws 1961, ch. 44, § 7; 1981, ch. 309, § 4.

24-14-8. Duties of local registrar.

The local registrar shall:

A. administer and enforce the provisions of the Vital Statistics Act and instructions, rules and regulations issued pursuant thereto;

B. require that certificates be completed and filed in accordance with the Vital Statistics Act and the rules and regulations issued pursuant thereto; and

C. transmit to the state registrar bimonthly, or more frequently when directed by that official, the certificates, reports or other returns filed with him.

History: 1953 Comp., § 12-4-30, enacted by Laws 1961, ch. 44, § 8; 1981, ch. 309, § 5.

24-14-9 to 24-14-11. Repealed.

24-14-12. Form and contents of certificates and reports.

A. In order to promote and maintain uniformity in the system of vital records and health statistics, the forms of certificates, reports and other returns required by the Vital Statistics Act or by regulations adopted pursuant to that act shall include as a minimum the items recommended by the federal agency responsible for national vital records and health statistics, subject to the approval of modifications by the department.

B. Each certificate, report and other document required to be registered under the Vital Statistics Act shall be on a form or in a format prescribed by the state registrar.

C. All vital records shall contain the date received for registration.

D. Information required in certificates or reports required or authorized by the Vital Statistics Act may be filed and registered by photographic, electronic or other means as prescribed by the state registrar; provided that certificates shall be filed and registered by either physical or photographic means.

History: 1953 Comp., § 12-4-34, enacted by Laws 1961, ch. 44, § 12; 1973, ch. 264, § 7; 1977, ch. 253, § 31; 1981, ch. 309, § 6; 2009, ch. 215, § 14.

24-14-13. Birth registration.

A. A certificate of birth for each live birth that occurs in this state shall be filed with the bureau or as otherwise directed by the state registrar within ten days after the birth and shall be registered if it has been completed and filed in accordance with this

section. When a birth, however, occurs on a moving conveyance, a birth certificate shall be registered in this state and the place where the child is first removed shall be considered the place of birth.

B. When a birth occurs in an institution, the person in charge of the institution or the person's designated representative shall obtain the personal data, prepare the certificate of birth, secure the signatures required and file it as directed in this section. The physician or other person in attendance shall certify the medical information required by the certificate of birth within ten working days after the birth in accordance with policies established by the institution where the birth occurred. The person in charge of the institution or the person's designee shall complete and sign the certificate of birth.

C. When a birth occurs outside an institution, the certificate of birth shall be prepared and filed by one of the following in the indicated order of priority:

(1) the physician in attendance at or immediately after the birth;

(2) any other person in attendance at or immediately after the birth; or

(3) the father, the mother or, in the absence of the father and the inability of the mother, the person in charge of the premises where the birth occurred.

D. If the mother was married at the time of either conception or birth, the name of the husband shall be entered on the certificate of birth as the father of the child, unless paternity has been determined pursuant to Subsection F or G of this section or by a court, in which case the name of the father as determined pursuant to Subsection F or G of this section or by the court shall be entered.

E. If the mother was not married at the time of either conception or birth, but the mother and father have signed under penalty of perjury an acknowledgment of paternity on a form provided by the bureau pursuant to the New Mexico Uniform Parentage Act [40-11A-101 to 40-11A-903 NMSA 1978], the father's name, date of birth and social security number shall be entered on the acknowledgment of paternity. The name of the father shall not be entered on the certificate of birth without such a written acknowledgment of paternity signed under penalty of perjury by the mother and the person to be named as the father, unless a determination of paternity has been made by a court, in which case the name of the father as determined by the court shall be entered.

F. At or before the birth of a child to an unmarried woman, the person in charge of the institution, a designated representative, the attending physician or midwife shall:

(1) provide an opportunity for the child's mother and father to sign under penalty of perjury an acknowledgment of paternity on a form provided by the bureau pursuant to the New Mexico Uniform Parentage Act. The completed acknowledgment of

paternity shall be filed with the bureau. The acknowledgment shall contain or have attached to it:

(a) a statement by the mother consenting to the assertion of paternity;

(b) a statement by the father that he is the father of the child;

(c) written information, furnished by the human services department [health care authority department], explaining the implications of signing, including legal parental rights and responsibilities; and

(d) the social security numbers of both parents; and

(2) provide written information, furnished by the human services department [health care authority department], to the mother and father, regarding the benefits of having the child's paternity established and of the availability of paternity establishment services and child support enforcement services.

G. If a married mother claims that her husband is not the father of the child, the husband signs under penalty of perjury a denial of paternity on a form provided by the bureau pursuant to the New Mexico Uniform Parentage Act and the non-husband agrees that he is the father, an acknowledgment of paternity may be signed under penalty of perjury by the mother and the non-husband. Upon filing the acknowledgment of paternity and the denial of paternity with the bureau, the name of the non-husband shall be entered on the certificate of birth as the father.

H. Pursuant to an interagency agreement for proper reimbursement, the bureau shall make available to the human services department [health care authority department] the birth certificate, the mother's and father's social security numbers and paternity acknowledgments or denials. The human services department [health care authority department] shall use these records only in conjunction with its duties as the state IV-D agency responsible for the child support program under Title IV-D of the federal Social Security Act.

I. Each party shall be provided with copies of any acknowledgment of paternity and any related denial of paternity.

J. The forms of acknowledgment of paternity and denial of paternity furnished by the bureau shall comply with the requirements of the New Mexico Uniform Parentage Act and shall be provided in English and in Spanish.

History: 1953 Comp., § 12-4-35, enacted by Laws 1961, ch. 44, § 13; 1981, ch. 309, § 7; 1993, ch. 287, § 1; 2009, ch. 215, § 15.

24-14-14. Unknown parentage; foundling registration.

A. Whoever assumes the custody of a living infant of unknown parentage shall report on a form and in the manner prescribed by the state registrar within ten days the following information:

(1) the date and place of finding;

(2) sex, color or race and approximate age of child;

(3) name and address of the person or institution with whom the child has been placed for care;

(4) name given to the child by the custodian; and

(5) other data required by the state registrar.

B. A report registered under this section constitutes the certificate of birth for the infant.

C. If the child is subsequently identified and a standard certificate of birth can be established, any report registered under this section shall be sealed and may be opened only by order of the district court or as provided by regulation.

History: 1953 Comp., § 12-4-36, enacted by Laws 1961, ch. 44, § 14; 1981, ch. 309, § 8.

24-14-15. Delayed registration of births.

A. When the birth of a person born in this state has not been registered, a certificate may be filed in accordance with regulations of the department. The certificate shall be registered subject to evidentiary requirements prescribed by regulation to substantiate the alleged facts of birth.

B. Certificates of birth registered one year or more after the date of birth shall show on their face the date of the delayed registration.

C. A summary statement of the evidence submitted in support of the delayed registration shall be endorsed on the certificate.

D. When an applicant does not submit the minimum documentation required in the regulations for delayed registration or when the state registrar finds reason to question the validity or adequacy of the certificate or the documentary evidence, the state registrar shall not register the delayed certificate and shall advise the applicant of the reason for this action.

E. The department may by regulation provide for the denial of an application for delayed registration which is not actively prosecuted.

History: 1953 Comp., § 12-4-37, enacted by Laws 1961, ch. 44, § 15; 1981, ch. 309, § 9.

24-14-16. Judicial procedure to establish facts of birth.

A. If a delayed certificate of birth is rejected under the provisions of Section 24-14-15 NMSA 1978, a petition may be filed with a court for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered.

B. The petition shall allege that:

(1) the person for whom a delayed certificate of birth is sought was born in this state;

(2) no record of birth of the person can be found in the bureau;

(3) diligent efforts by the petitioner have failed to obtain the evidence required in accordance with Section 24-14-15 NMSA 1978;

(4) the state registrar has refused to register a delayed certificate of birth; and

(5) any other allegations as may be required.

C. The petition shall be accompanied by a statement of the registration official made in accordance with Section 24-14-15 NMSA 1978 and all documentary evidence that was submitted to the registration official in support of the registration. The petition shall be sworn to by the petitioner.

D. The court shall fix a time and place for hearing the petition and shall give the registration official who refused to register the petitioner's delayed certificate of birth ten days' notice of the hearing. The official or the official's authorized representative may appear and testify in the proceeding.

E. If the court finds from the evidence presented that the person for whom a delayed certificate of birth is sought was born in this state, it shall make findings as to the place and date of birth, parentage and other findings as the case may require and shall issue an order to establish a record of birth. This order shall include the birth data to be registered, a description of the evidence presented in the manner prescribed by Section 24-14-15 NMSA 1978 and the date of the court's action.

F. The court shall determine the parent-child relationship of the mother and father pursuant to the New Mexico Uniform Parentage Act [40-11A-101 to 40-11A-903 NMSA 1978].

G. The clerk of the court shall forward each order to the state registrar not later than the tenth day of the calendar month following the month in which it was entered. The order shall be registered by the state registrar and shall constitute the record of birth from which copies may be issued in accordance with Sections 24-14-28 and 24-14-29 NMSA 1978.

History: 1953 Comp., § 12-4-38, enacted by Laws 1961, ch. 44, § 16; 1981, ch. 309, § 10; 2009, ch. 215, § 16.

24-14-17. New birth certificates following adoption, legitimation and paternity determination.

A. The state registrar shall establish a new certificate of birth for a person born in this state when he receives the following:

(1) a report of adoption as provided in this section, a report of adoption prepared and filed in accordance with the laws of another state or country or a certified copy of the decree of adoption together with the information necessary to identify the original certificate of birth and to establish a new certificate of birth; except that a new certificate of birth shall not be established if so requested by the court decreeing the adoption, the adoptive parents or the adopted person; or

(2) a request that a new certificate of birth be established and evidence as required by regulation proving that the person has been legitimated or that a court has determined the paternity of the person.

B. When a new certificate of birth is established, the actual place and date of birth shall be shown. It shall be substituted for the original certificate of birth. Thereafter, the original certificate and the evidence of adoption, paternity determination or legitimation shall not be subject to inspection except upon order of a court or in accordance with the provisions of Section 24-14-13 NMSA 1978 or in the case of a single adoptive parent.

C. Upon receipt of notice of annulment of adoption, the original certificate of birth shall be restored to its place in the files, and the new certificate and evidence shall not be subject to inspection except upon order of a court.

D. If no certificate of birth is on file for the person for whom a new certificate is to be established under this section, a delayed certificate of birth shall be filed with the state registrar as provided in Section 24-14-15 NMSA 1978 before a new certificate of birth is established.

E. For each adoption decreed by a court in this state, the court shall require the preparation of a report of adoption on a form prescribed and furnished by the state registrar. The report shall include such facts as are necessary to locate and identify the certificate of birth of the person adopted, shall provide information necessary to

establish a new certificate of birth of the person adopted and shall identify the order of adoption and be certified by the clerk of the court.

History: 1953 Comp., § 12-4-39, enacted by Laws 1961, ch. 44, § 17; 1973, ch. 264, § 8; 1981, ch. 309, § 11; 1993, ch. 287, § 2.

24-14-18. Report of induced abortions.

A. Each induced abortion which occurs in this state shall be reported to the state registrar within five days by the person in charge of the institution in which the induced abortion was performed. If the induced abortion was performed outside an institution, the attending physician shall prepare and file the report.

B. The reports required under this section are statistical reports to be used only for medical and health purposes and shall not be incorporated into the permanent official records of the system of vital statistics. The report shall not include the name or address of the patient involved in the abortion. The department shall not release the name or address of the physician involved in the abortion. A schedule for the disposition of these reports shall be provided for by regulation.

History: 1953 Comp., § 12-4-39.1, enacted by Laws 1977, ch. 206, § 2; 1981, ch. 309, § 12.

24-14-19. Adoption of foreign-born; certificate of birth.

A. The state registrar shall establish a certificate of birth for a person of foreign birth adopted under New Mexico law when the registrar receives:

(1) a certified copy of a judgment of adoption granted by the court;

(2) an order issued by the court to establish a certificate of birth for that adopted person; and

(3) any other evidence as provided in Section 24-14-17 NMSA 1978 necessary to establish a new certificate of birth.

B. The certificate of birth established under this section shall be on a form prescribed by the state registrar and shall show the probable country of birth, pursuant to the findings of the court, and shall state that the certificate is not evidence of United States citizenship.

History: 1953 Comp., § 12-4-39.1, enacted by Laws 1977, ch. 223, § 1; 1981, ch. 309, § 13.

24-14-20. Death registration.

A. A death certificate for each death that occurs in this state shall be filed within five days after the death and prior to final disposition. The death certificate shall be registered by the state registrar if it has been completed and filed in accordance with this section, subject to the exception provided in Section 24-14-24 NMSA 1978; provided that:

(1) if the place of death is unknown but the dead body is found in this state, a death certificate shall be filed with a local registrar within ten days after the occurrence. The place where the body is found shall be shown as the place of death. If the date of death is unknown, it shall be approximated by the state medical investigator; and

(2) if death occurs in a moving conveyance in the United States and the body is first removed from the conveyance in this state, the death shall be registered in this state and the place where the body is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in this state, the death shall be registered in this state, but the certificate shall show the actual place of death insofar as can be determined by the state medical investigator.

B. The funeral service practitioner or person acting as a funeral service practitioner who first assumes custody of a dead body shall:

(1) file the death certificate;

(2) obtain the personal data from the next of kin or the best qualified person or source available; and

(3) obtain the medical certification of cause of death.

C. The medical certification shall be completed and signed within forty-eight hours after death by the physician or nurse practitioner in charge of the patient's care for the illness or condition that resulted in death, except when inquiry is required by law. Except as provided in Subsection D of this section, in the absence of the physician or nurse practitioner, or with the physician's or the nurse practitioner's approval, the medical certification may be completed and signed by the physician's associate physician or the nurse practitioner's associate nurse practitioner, the chief medical officer of the institution in which death occurred or the physician who performed an autopsy on the decedent; provided that the individual has access to the medical history of the case and views the deceased at or after death and that death is due to natural causes.

D. Unless there is reasonable cause to believe that the death is not due to natural causes, a registered nurse employed by a nursing home or a hospice agency may pronounce the death of a resident of the nursing home and a registered nurse employed by a hospital may pronounce the death of a patient of the hospital. The nurse shall

have access to the medical history of the case and view the deceased at or after death, and the individual who completes the medical certification shall not be required to view the deceased at or after death. The death shall be pronounced pursuant to procedures or facility protocols prescribed by the hospital for patients or by the physician who is the medical director of the nursing home for residents. The procedures or facility protocols shall ensure that the medical certification of death is completed in accordance with the provisions of Subsection C of this section.

E. For purposes of this section:

(1) "hospital" means a public hospital, profit or nonprofit private hospital or a general or special hospital that is licensed as a hospital by the department of health;

(2) "nurse practitioner" means a registered nurse who is licensed by the board of nursing for advanced practice as a certified nurse practitioner and whose name and pertinent information are entered on the list of certified nurse practitioners maintained by the board of nursing; and

(3) "nursing home" means any nursing institution or facility required to be licensed under state law as a nursing facility by the public health division of the department of health, whether proprietary or nonprofit, including skilled nursing home facilities.

F. When death occurs without medical attendance as set forth in Subsection C or D of this section or when death occurs more than ten days after the decedent was last treated by a physician, the case shall be referred to the state medical investigator for investigation to determine and certify the cause of death.

G. An amended death certificate based on an anatomical observation shall be filed within thirty days of the completion of an autopsy.

History: 1953 Comp., § 12-4-40, enacted by Laws 1961, ch. 44, § 18; 1973, ch. 264, § 9; 1978 Comp., § 24-14-20, 1981, ch. 309, § 14; 1995, ch. 104, § 1; 2001, ch. 83, § 1; 2009, ch. 29, § 1; 2023, ch. 101, § 1.

24-14-21. Delayed registration of death.

A. When a death occurring in this state has not been registered, a certificate may be filed in accordance with regulations of the board of medical investigators. The certificate shall be registered subject to evidentiary requirements as prescribed by regulation to substantiate the alleged facts of death.

B. Certificates of death registered one year or more after the date of death shall be marked "delayed" and shall show on their face the date of the delayed registration.

History: 1953 Comp., § 12-4-41, enacted by Laws 1961, ch. 44, § 19; 1973, ch. 264, § 10; 1981, ch. 309, § 15.

24-14-22. Reports of spontaneous fetal death.

A. Each spontaneous fetal death that occurs in this state after the fetus has attained a gestational age of at least twenty weeks, or if gestational age is unknown when the fetus weighs not less than three hundred fifty grams, shall be reported to the state registrar within ten days of fetal death with the bureau or as the state registrar directs.

B. The state registrar shall incorporate registrations of fetal death into the vital records of the bureau.

C. When a spontaneous fetal death required to be reported by this section occurs in an institution, the person in charge of the institution or the designated representative of that person shall report the spontaneous fetal death and shall advise the woman who delivered under circumstances in which spontaneous fetal death occurred, or a family member whom the woman designates, of the option to request a report of spontaneous fetal death and a certificate of still birth.

D. When a spontaneous fetal death for which a report of spontaneous fetal death is required occurs on a moving conveyance and the fetus is first removed from the conveyance in this state, the fetal death shall be reported in this state. The place where the fetus was first removed from the conveyance shall be considered the place of fetal death.

E. When a spontaneous fetal death required to be reported by this section occurs and the place of the spontaneous fetal death is unknown, the place where the dead fetus was found shall be considered the place of spontaneous fetal death.

F. When a spontaneous fetal death required to be reported by this section occurs without medical attendance at or immediately after the delivery or when inquiry is required by law, the state medical investigator shall investigate the cause of fetal death and shall prepare and file the report.

G. The name of the woman who delivered under circumstances in which a spontaneous fetal death occurred and, if the woman requests it, the name of the father or second parent shall be entered on the spontaneous fetal death report in accordance with the provisions of Section 24-14-13 NMSA 1978.

H. When a spontaneous fetal death occurs, the state registrar shall record the name of the fetus upon the registration of spontaneous fetal death when requested by the woman who delivered under circumstances in which the spontaneous fetal death occurred, or when requested by a family member whom the woman designates.

I. A delayed registration of spontaneous fetal death may be filed in accordance with Section 24-14-21 NMSA 1978; provided that the woman who delivered under circumstances in which a spontaneous fetal death occurred, or a family member whom the woman designates, may present a copy of the report of spontaneous fetal death or other medical records by the woman's health care provider, who attended the delivery or who has received the woman's medical records as they pertain to the delivery, to substantiate the alleged facts of the spontaneous fetal death as the state registrar establishes by rule.

J. When the bureau has in its files a registration of spontaneous fetal death or receives evidence of a spontaneous fetal death, the state registrar shall produce a copy of a report of spontaneous fetal death upon the request of the woman who delivered under circumstances in which a spontaneous fetal death occurred, or upon the request of a family member whom the woman designates, without regard to the date on which a report of spontaneous fetal death was filed or when the spontaneous fetal death was registered.

K. For purposes of this section, "still birth" means an unintended, intrauterine spontaneous fetal death that occurs:

(1) after the fetus has attained a gestational age of at least twenty weeks; or

(2) when the fetus has attained a weight of not less than three hundred fifty grams, if gestational age is unknown.

History: 1953 Comp., § 12-4-42, enacted by Laws 1961, ch. 44, § 20; 1981, ch. 309, § 16; 2013, ch. 183, § 2.

24-14-22.1. Certificates of still birth.

A. The state registrar shall establish a certificate of still birth. A person required to report a spontaneous fetal death shall inform a woman who has delivered under circumstances in which a spontaneous fetal death has occurred, or a family member whom the woman designates, that the report of spontaneous fetal death and a certificate of still birth are available from the bureau upon request. Upon the request of a woman who delivered under circumstances in which a spontaneous fetal death occurred, or the request of a family member whom the woman designates, a certificate of still birth shall be completed and filed in accordance with Section 24-14-13 NMSA 1978.

B. Notwithstanding the provisions of Subsection A of this section, and upon the request of a woman who delivered under circumstances in which a spontaneous fetal death occurred, or the request of a family member whom the woman designates, the state registrar shall issue a certificate of still birth without regard to the date on which a report of spontaneous fetal death was filed, when the spontaneous fetal death was registered or when a report of spontaneous fetal death was issued.

C. A certificate of still birth shall include:

(1) the following sentence: "THIS CERTIFICATE OF STILL BIRTH CANNOT BE USED AS PROOF OF A LIVE BIRTH, FOR IDENTIFICATION OR FOR ANY OTHER PURPOSE."; and

(2) only those of the following that are requested by the woman who delivered under circumstances in which a spontaneous fetal death occurred:

(a) the sex of the still-born fetus;

(b) the record number of the report of spontaneous fetal death;

(c) the date and time of delivery;

(d) the county of delivery; or

(e) the full name, birth date and birthplace of the woman who delivered under circumstances in which a spontaneous fetal death occurred.

D. Upon the request of the woman who delivered under circumstances in which a spontaneous fetal death occurred, the certificate of still birth shall include a name for the fetus delivered under circumstances in which the spontaneous fetal death occurred.

E. A certificate of still birth shall not be used to calculate live birth statistics.

F. This section provides for a person's right to request a certificate of still birth and the procedures pursuant to which a person may obtain a certificate of still birth. The provisions of this section shall not be construed to create any other right, privilege or entitlement or to abrogate any existing right, privilege or entitlement.

G. For purposes of this section, "still birth" means an unintended, intrauterine spontaneous fetal death that occurs:

(1) after the fetus has attained a gestational age of at least twenty weeks; or

(2) when the fetus has attained a weight of not less than three hundred fifty grams, if gestational age is unknown.

History: Laws 2013, ch. 183, § 4.

24-14-23. Permits; authorization for final disposition.

A. For deaths or spontaneous fetal deaths which have occurred in this state, no burial-transit permit shall be required for final disposition of the remains if the disposition occurs in this state and is performed by a funeral service practitioner or direct disposer.

B. A burial-transit permit shall be issued by the state registrar or a local registrar for those bodies which are to be transported out of the state for final disposition or when final disposition is being made by a person other than a funeral service practitioner or direct disposer.

C. A burial-transit permit issued under the law of another state or country which accompanies a dead body or fetus brought into this state shall be authority for final disposition of the body or fetus in this state.

D. A permit for disinterment and reinterment shall be required prior to disinterment of a dead body or fetus except as authorized by regulation or otherwise provided by law. The permit shall be issued by the state registrar or state medical investigator to a licensed funeral service practitioner or direct disposer.

E. A permit for cremation of a body shall be required prior to the cremation. The permit shall be issued by the state medical investigator to a licensed funeral service practitioner, direct disposer or any other person who makes the arrangements for final disposition.

History: 1953 Comp., § 12-4-43, enacted by Laws 1961, ch. 44, § 21; 1981, ch. 309, § 17; 1985, ch. 230, § 1.

24-14-24. Extension of time.

A. The department may, by regulation and upon conditions as it may prescribe to assure compliance with the purposes of the Vital Statistics Act, provide for the extension of the periods prescribed in Sections 24-14-20, 24-14-22 and 24-14-23 NMSA 1978 for the filing of death certificates, spontaneous fetal death reports, medical certifications of cause of death and for the obtaining of burial-transit permits in cases where compliance with the applicable prescribed period would result in undue hardship.

B. Regulations of the department may provide for the issuance of a burial-transit permit prior to the filing of a certificate upon conditions designed to assure compliance with the purposes of the Vital Statistics Act in cases where compliance with the requirement that the certificate be filed prior to the issuance of the permit would result in undue hardship.

History: 1953 Comp., § 12-4-44, enacted by Laws 1961, ch. 44, § 22; 1973, ch. 264, § 11; 1977, ch. 253, § 32; 1981, ch. 309, § 18.

24-14-25. Correction and amendment of vital records.

A. A certificate or report registered under the Vital Statistics Act may be amended only in accordance with that act and regulations adopted by the department pursuant to that act to protect the integrity and accuracy of vital records and health statistics.

B. Upon receipt of a certified copy of a court order changing the name of a person born in this state and upon request of the person or the person's parent, guardian or legal representative, the state registrar shall amend the original certificate of birth to reflect the new name.

C. Upon request and receipt of an acknowledgment of paternity signed under penalty of perjury by both parents of a child born to an unmarried mother or, in the case of a married mother, upon receipt of an acknowledgment of paternity signed under penalty of perjury by the mother and the non-husband and of a denial of paternity signed under penalty of perjury by the husband, the state registrar shall amend a certificate of birth to show the paternity if paternity is not shown on the birth certificate. The certificate of birth shall not be marked "amended".

D. Upon receipt of a statement signed under penalty of perjury by an individual born in this state, or the individual's parent, guardian or legal representative, indicating the gender identity of the individual, together with a certified copy of an order changing the name of the individual, if applicable, the certificate of birth of the individual shall be reissued to reflect a designation of male, female or X, as prescribed by regulation. The certificate of birth shall not be marked "amended" pursuant to Subsection F of this section.

E. When an applicant does not submit the minimum documentation required in the regulations for amending a vital record or when the state registrar has reasonable cause to question the validity or adequacy of the applicant's statements or statements made under penalty of perjury or the documentary evidence and if the deficiencies are not corrected, the state registrar shall not amend the vital records and shall advise the applicant of the reason for this action.

F. A certificate or report that is amended under this section shall be marked "amended", except as otherwise provided in Subsections C and D of this section. The date of the amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made a part of the record. The department shall prescribe by regulation the conditions under which additions or minor corrections may be made to certificates or records within one year after the date of the event without the certificate or record being marked "amended".

G. For the purposes of this section, "X" refers to a gender other than male or female or an, undesignated gender.

History: 1953 Comp., § 12-4-45, enacted by Laws 1961, ch. 44, § 23; 1981, ch. 309, § 19; 2009, ch. 215, § 17; 2019, ch. 89, § 1.

24-14-26. Reproduction of records.

To preserve vital records, the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and files in his office.

The reproductions when certified by him shall be accepted as the original record. The documents from which permanent reproductions have been made and verified may be disposed of as provided by regulation.

History: 1953 Comp., § 12-4-46, enacted by Laws 1961, ch. 44, § 24; 1981, ch. 309, § 20.

24-14-27. Disclosure of records.

A. The state registrar or other custodian of vital records shall not permit inspection of or disclosure of information contained in vital records or copying or issuance of a copy of all or part of any record except as authorized by law.

B. The department shall provide access to record level data required by the New Mexico health policy commission. The New Mexico health policy commission may only release record level data obtained from vital records in the aggregate. For the purposes of this subsection, "record level data" means one or more unique and non-aggregated data elements relating to a single identifiable individual. The department may authorize the disclosure of data contained in vital records for other research purposes.

C. When one hundred years have elapsed after the date of birth or fifty years have elapsed after the date of death, the vital records of these events in the custody of the state registrar shall become open public records, and information shall be made available in accordance with regulations that provide for the continued safekeeping of the records; provided that vital records of birth shall not become open public records prior to the individual's death.

History: 1953 Comp., § 12-4-47, enacted by Laws 1961, ch. 44, § 25; 1981, ch. 309, § 21; 1994, ch. 59, § 1; 2017, ch. 87, § 29.

24-14-28. Copies or data from the system of vital statistics.

A. In accordance with the Vital Statistics Act and the regulations adopted pursuant to that act:

(1) the state registrar shall, upon receipt of a written application, issue a certified copy of any certificate or record in the state registrar's custody to anyone demonstrating a tangible and direct interest, except that:

(a) certified copies of birth records shall exclude all medical information unless a complete certificate is specifically requested and the request for a complete certificate is approved by the state registrar; and

(b) issuance of copies of birth records shall be subject to the provisions of the Missing Child Reporting Act [repealed];

(2) a certified copy of a certificate or any part thereof, including records reproduced from paper documents or photographic, magnetic or electronic files, shall be considered for all purposes the same as the original and is prima facie evidence of the facts therein stated; provided that the evidentiary value of a certificate or record filed more than one year after the event or a record that has been amended shall be determined by the judicial or administrative body or official before whom the certificate is offered as evidence;

(3) the agency of the United States government responsible for national vital statistics may be furnished copies or data as it may require for national statistics, upon the condition that the data shall not be used for other than statistical purposes unless so authorized by the state registrar;

(4) at the discretion of the state registrar, federal, state, local and other public or private agencies may upon request be furnished copies or data for statistical or administrative purposes upon the conditions as may be prescribed by the department;

(5) no person shall prepare or issue any report of an induced abortion or any certificate that purports to be an original, certified copy or copy of a certificate of birth, death or spontaneous fetal death or reproduction of a certified copy except as authorized in the Vital Statistics Act or regulations adopted pursuant to that act;

(6) the state registrar may, by written agreement, transmit copies of records and other reports required by the Vital Statistics Act to offices of vital statistics outside this state when the records or other reports relate to residents of those jurisdictions or persons born outside those jurisdictions. The agreement shall require that the copies be used for statistical purposes only and shall provide for the retention and disposition of copies. Copies received by the state registrar from offices of vital statistics in other states shall be handled in the manner prescribed in this section; and

(7) the state registrar shall, upon receipt of a written application from an unaccompanied youth, issue a certified copy of that youth's birth record to the youth, without requiring a signature of an adult.

B. A local education agency homeless liaison, a school counselor and a school nurse each have a tangible and direct interest pursuant to Subsection A of this section in a certified copy of the birth record of a homeless child or youth who is enrolled in the local education agency and in a certified copy of the birth record of a younger sibling of a homeless child or youth who is enrolled in the local education agency.

C. A social worker in this state has a tangible and direct interest pursuant to Subsection A of this section in a:

(1) certified copy of the birth record of a homeless child or youth who is a client of the social worker; and

(2) certified copy of the birth record of a younger sibling of a homeless child or youth who is a client of the social worker.

D. For the purposes of this section:

(1) "homeless child or youth" means an individual who is twenty-five years of age or younger and lacks a fixed, regular and adequate nighttime residence, including an individual who:

(a) lives in the housing of another person due to that individual's loss of housing, economic hardship or other reason related to that individual's lack of a fixed residence;

(b) lives in a motel, hotel, trailer park or camping ground due to that individual's lack of alternative adequate accommodations;

(c) lives in an emergency or transitional shelter;

(d) sleeps in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; or

(e) lives in an automobile, a park, a public space, an abandoned building, substandard housing, a bus station, a train station or a similar setting; and

(2) "unaccompanied youth" means an individual who is twenty-five years of age or younger, is not in the physical custody of a parent or legal guardian and lacks a fixed, regular and adequate nighttime residence, including an individual who:

(a) lives in the housing of another person due to that individual's loss of housing, economic hardship or other reason related to that individual's lack of a fixed residence;

(b) lives in a motel, hotel, trailer park or camping ground due to that individual's lack of a fixed residence;

(c) lives in an emergency or transitional shelter;

(d) sleeps in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; or

(e) lives in an automobile, a park, a public space, an abandoned building, substandard housing, a bus station, a train station or a similar setting.

History: 1953 Comp., § 12-4-48, enacted by Laws 1961, ch. 44, § 26; 1972, ch. 34, § 1; 1977, ch. 206, § 3; 1981, ch. 309, § 22; 1987, ch. 25, § 5; 2021, ch. 100, § 1.

24-14-29. Fees for copies and searches.

A. The fee for each search of a vital record to produce a certified copy of a birth certificate shall be ten dollars ($10.00) and shall include one certified copy of the record, if available. A fee shall not be charged for a certified copy of a birth certificate of a homeless individual.

B. The fee for the establishment of a delayed record or for the revision or amendment of a vital record, as a result of an adoption, a legitimation, a correction or other court-ordered change to a vital record, shall be ten dollars ($10.00). The fee shall include one certified copy of the delayed record.

C. The fee for each search of a vital record to produce a copy of a report of spontaneous fetal death or a certificate of still birth shall be five dollars ($5.00) and shall include one certified copy of the record of fetal death, if available.

D. The fee for each search of a vital record to produce a certified copy of a death certificate shall be five dollars ($5.00) and shall include one certified copy of the record, if available.

E. Revenue from the fees imposed in this section shall be distributed as follows:

(1) an amount equal to three-fifths of the revenue from the fee imposed by Subsection A of this section, an amount equal to one-half of the revenue from the fee imposed by Subsection B of this section and an amount equal to one-fifth of the revenue from the fee imposed by Subsection D of this section shall be distributed to the day-care fund; and

(2) the remainder of the revenue from the fees imposed by Subsections A, B, C and D of this section shall be deposited in the state general fund.

F. For the purposes of this section, "homeless individual" means an individual:

(1) who lacks a fixed, regular and adequate nighttime residence, including an individual who:

(a) lives in the housing of another person due to that individual's loss of housing, economic hardship or other reason related to that individual's lack of a fixed residence;

(b) lives in a motel, hotel, trailer park or camping ground due to the lack of alternative adequate accommodations;

(c) lives in an emergency or transitional shelter;

(d) sleeps in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; or

(e) lives in an automobile, a park, a public space, an abandoned building, substandard housing, a bus station, a train station or a similar setting; and

(2) whose homelessness can be verified through an attestation, which shall not be required to be notarized, by one of the following:

(a) a public or private governmental or nonprofit agency that provides services to homeless individuals;

(b) a local education agency homeless liaison, school counselor or school nurse;

(c) a social worker licensed in this state; or

(d) the homeless individual.

History: 1953 Comp., § 12-4-49, enacted by Laws 1961, ch. 44, § 27; 1973, ch. 264, § 12; 1981, ch. 309, § 23; 1987, ch. 62, § 1; 1988, ch. 114, § 1; 2013, ch. 183, § 3; 2021, ch. 100, § 2.

24-14-29.1. Day-care fund created; use; appropriation.

There is created in the state treasury a fund to be known as the "day-care fund". The fund shall be invested by the state treasurer as other state funds are invested. The fund shall consist of distributions of revenue collected since July 1, 1987 and future revenues collected pursuant to Section 24-14-29 NMSA 1978. All balances in the day-care fund are appropriated to the children, youth and families department for use in implementing the income-eligible day-care program under the Social Services Block Grant Act Title XX.

History: Laws 1988, ch. 114, § 2; 1989, ch. 324, § 19; 1993, ch. 151, § 1.

24-14-30. Duty to furnish information.

A. Any person having knowledge of the facts regarding any birth, death, spontaneous fetal death or induced abortion shall furnish this information upon demand to the state registrar.

B. Not later than the tenth day of the month following the month of occurrence, each funeral service practitioner shall send to the state registrar a list showing all dead bodies embalmed or otherwise prepared for final disposition during the preceding month. Such list shall be made on forms prescribed by the state registrar.

History: 1953 Comp., § 12-4-50, enacted by Laws 1961, ch. 44, § 28; 1981, ch. 309, § 24.

24-14-31. Penalties.

A. Except for violations of Section 24-14-18 NMSA 1978, any person is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978, who willfully and knowingly:

(1) makes any false statement or supplies any false information in a report, record or certificate required to be filed;

(2) with the intent to deceive, alters, amends, counterfeits, copies or mutilates any report, record or certificate, application or supporting documentation;

(3) uses or attempts to use or furnishes to another for use for any purpose of deception any certificate, record, report or certified copy that has been altered, amended or mutilated or that contains false information in whole or in part, or that is related to the birth or death of another person, whether living or dead; or

(4) neglects or violates any of the provisions of the Vital Statistics Act [Chapter 24, Article 14 NMSA 1978] or refuses to perform any of the duties imposed upon the person by that act.

B. Any person who willfully and knowingly permits inspection of or discloses information contained in vital statistics records of adoptions or induced abortions or copies or issues a copy of all or part of any record of an adoption or induced abortion, except as authorized by law, is guilty of a fourth degree felony and shall be sentenced in accordance with the provisions of the Criminal Sentencing Act [Chapter 31, Article 18 NMSA 1978].

History: 1953 Comp., § 12-4-51, enacted by Laws 1961, ch. 44, § 29; 1977, ch. 206, § 4; 1981, ch. 309, § 25; 1993, ch. 247, § 1; 2017, ch. 87, § 30.

ARTICLE 14A
Health Information Systems

24-14A-1. Short title.

Chapter 24, Article 14A NMSA 1978 may be cited as the "Health Information System Act".

History: Laws 1989, ch. 29, § 1; 1994, ch. 59, § 2.

24-14A-2. Definitions.

As used in the Health Information System Act:

A. "aggregate data" means data that are obtained by combining like data elements in a manner that precludes specific identification of a single client;

B. "data source" or "data provider" means a person that possesses health information, including the health care authority, any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third-party payer and any public entity that has health information;

C. "department" means the department of health;

D. "health information" or "health data" means any data relating to health care; health status, including environmental, social and economic factors; the health system; or health costs and financing;

E. "hospital" means any general or special hospital licensed by the health care authority, whether publicly or privately owned;

F. "long-term care facility" means any skilled nursing facility or nursing facility licensed by the health care authority, whether publicly or privately owned;

G. "record-level data" means a medical record that contains unique and nonaggregated data elements that relate to a single identifiable individual; and

H. "third-party payer" means any public or private payer of health care services and includes health maintenance organizations and health insurers.

History: Laws 1989, ch. 29, § 2; 1994, ch. 59, § 3; 2009, ch. 166, § 1; 2012, ch. 15, § 1; 2021, ch. 71, § 1; 2024, ch. 39, § 20.

24-14A-3. Health information system; creation; duties of department.

A. The "health information system" is created for the purpose of assisting the department, legislature and other agencies and organizations in the state's efforts in collecting, analyzing and disseminating health information to assist:

(1) in the performance of health planning and policymaking functions, including identifying personnel, facility, education and other resource needs and allocating financial, personnel and other resources where appropriate;

(2) consumers in making informed decisions regarding health care; and

(3) in administering, monitoring and evaluating a statewide health plan.

B. In carrying out its powers and duties pursuant to the Health Information System Act, the department shall not duplicate databases that exist in the public sector or databases in the private sector to which it has electronic access. Every governmental entity shall provide the department with access to its health-related data as needed by the department. The department shall collect data from data sources in the most cost-effective and efficient manner.

C. The department shall establish, operate and maintain the health information system.

D. In establishing, operating and maintaining the health information system, the department shall:

(1) obtain information on the following health factors:

(a) mortality and natality, including accidental causes of death;

(b) morbidity;

(c) health behavior;

(d) disability;

(e) health system costs, availability, utilization and revenues;

(f) environmental factors;

(g) health personnel;

(h) demographic factors;

(i) social, cultural and economic conditions affecting health, including language preference;

(j) family status;

(k) medical and practice outcomes as measured by nationally accepted standards and quality of care; and

(l) participation in clinical research trials;

(2) give the highest priority in data gathering to information needed to implement and monitor progress toward achievement of the state health policy, including determining where additional health resources such as personnel, programs and facilities are most needed, what those additional resources should be and how existing resources should be reallocated;

(3) standardize collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for collecting and reporting health information;

(4) take adequate measures to provide health information system security for all health data acquired under the Health Information System Act and protect individual patient and health care practitioner confidentiality. The right to privacy for the individual shall be a major consideration in the collection and analysis of health data and shall be protected in the reporting of results;

(5) adopt and promulgate rules necessary to establish and administer the provisions of the Health Information System Act, including an appeals process for data sources and procedures to protect data source proprietary information from public disclosure;

(6) establish definitions, formats and other common information standards for core health data elements of the health information system in order to provide an integrated financial, statistical and clinical health information system, including a geographic information system, that allows data sharing and linking across databases maintained by data sources and federal, state and local public agencies;

(7) develop and maintain health and health-related data inventories and technical documentation on data holdings in the public and private sectors;

(8) collect, analyze and make available health data to support preventive health care practices and to facilitate the establishment of appropriate benchmark data to measure performance improvements over time;

(9) establish and maintain a systematic approach to the collection and storage of health data for longitudinal, demographic and policy impact studies;

(10) use expert system-based protocols to identify individual and population health risk profiles and to assist in the delivery of primary and preventive health care services;

(11) collect health data sufficient for consumers to be able to evaluate health care services, plans, providers and payers and to make informed decisions regarding quality, cost and outcome of care across the spectrum of health care services, providers and payers;

(12) collect comprehensive information on major capital expenditures for facilities, equipment by type and by data source and significant facility capacity reductions; provided that for the purposes of this paragraph and Section 24-14A-5 NMSA 1978, "major capital expenditure" means purchases of at least one million dollars ($1,000,000) for construction or renovation of facilities and at least five hundred thousand dollars ($500,000) for purchase or lease of equipment, and "significant facility

capacity reductions" means those reductions in facility capacities as defined by the department;

(13) serve as a health information clearinghouse, including facilitating private and public collaborative, coordinated data collection and sharing and access to appropriate data and information, maintaining patient and client confidentiality in accordance with state and federal requirements;

(14) collect data in the most cost-efficient and effective method feasible and adopt rules that place a limit on the maximum amount of unreimbursed costs that a data source can incur in any year for the purposes of complying with the data requirements of the Health Information System Act; and

(15) identify disparities in health care access and quality by aggregating the information collected pursuant to Paragraph (1) of this subsection by population subgroups to include race, ethnicity, gender and age.

History: Laws 1989, ch. 29, § 3; 1994, ch. 59, § 4; 2005, ch. 321, § 12; 2005, ch. 322, § 1; 2012, ch. 15, § 2; 2015, ch. 121, § 1.

24-14A-3.1. Repealed.

History: Laws 1994, ch. 59, § 13; repealed Laws 2005, ch. 321, § 14.

24-14A-3.2. Repealed.

History: Laws 1994, ch. 59, § 14; repealed Laws 2005, ch. 321, § 14.

24-14A-4. Health information system; applicability.

A. All data sources shall participate in the health information system. Requests for health data under the Health Information System Act from a member of a data source category shall, where reasonable and equitable, be made to all members of that data source category.

B. Upon making any request for health data pursuant to the Health Information System Act, the department shall provide reasonable deadlines for compliance and shall give notice that noncompliance may subject the person to a civil penalty pursuant to Section 24-14A-10 NMSA 1978.

C. To the extent possible, the health information system shall be established in a manner to facilitate the exchange of information with other databases, including those maintained by the Indian health service and various agencies of the federal government.

History: Laws 1989, ch. 29, § 4; 1994, ch. 59, § 5; 2012, ch. 15, § 3.

24-14A-4.1. Annual review of data needs.

At least once each year, the department shall review its data collection requirements to determine the relevancy of the data elements on which it collects data and review its regulations and procedures for collecting, analyzing and reporting data for efficiency, effectiveness and appropriateness. The review shall consider the cost incurred by data sources to collect and submit data.

History: Laws 1994, ch. 59, § 11; 2005, ch. 321, § 13; 2012, ch. 15, § 4.

24-14A-4.2. Investigatory powers.

The department has the right to verify the accuracy of data provided by any data source. The verification may include requiring the data source to submit documentation sufficient to verify the accuracy of the data in question or to provide direct inspection during normal business hours of only the records and documents that pertain directly to the data in question; provided that no data source shall be required to expend more than twenty-five thousand dollars ($25,000) each year to comply with the provisions of this section.

History: Laws 1994, ch. 59, § 12; 2012, ch. 15, § 5.

24-14A-4.3. Agency cooperation.

All state agencies and political subdivisions shall cooperate with and assist the department in carrying out the provisions of the Health Information System Act, including sharing information and joining in any appropriate health information system.

History: Laws 1994, ch. 59, § 15; 2012, ch. 15, § 6.

24-14A-5. Health information system; implementation; regulations.

In order to minimize the imposition of new reporting requirements on persons subject to the provisions of the Health Information System Act, the regulations to the extent reasonably possible shall provide that:

A. data shall be collected in a uniform manner;

B. when practicable, data collection shall be through the use of a standardized billing form as required by law;

C. other health data required to be submitted may include:

(1) data that would customarily be collected in the ordinary course of business for the data source;

(2) annual audited financial statements customarily prepared by a data source;

(3) information on major capital expenditures;

(4) data established by regulation to be collected to carry out the requirements of the Health Information System Act; and

(5) data required to be collected by other state or federal laws; and

D. annual surveys or collection of data may be used as an alternative to collection of health data from some health service providers to the extent it can be shown that the information collected will meet validity and quality standards.

History: Laws 1989, ch. 29, § 5; 1994, ch. 59, § 6.

24-14A-6. Health information system; access.

A. Access to data in the health information system shall be provided in accordance with rules adopted by the department pursuant to the Health Information System Act.

B. A data provider may obtain data it has submitted to the system, as well as aggregate data, but, except as provided in Subsection D of this section, it shall not have access to data submitted by another provider that are limited only to that provider unless those data are aggregated data and publicly disseminated by the department. Except as provided in Subsection D of this section, in no event may a data provider obtain data regarding an individual patient except in instances where the data were originally submitted by the requesting provider. Prior to the release of any data, in any form, data sources shall be permitted the opportunity to verify the accuracy of the data pertaining to that data source. Data identified in writing as inaccurate shall be corrected prior to the data's release. Time limits shall be set for the submission and review of data by data sources, and penalties shall be established for failure to submit and review the data within the established time.

C. Any person may obtain any aggregate data publicly disseminated by the department.

D. Through a secure delivery or transmission process, the department may share record-level data with the health care authority or a federal agency that is authorized to collect, analyze or disseminate health information. The department shall remove identifiable individual or provider information from the record-level data prior to its disclosure to the federal agency. In providing hospital information under an agreement or arrangement with a federal agency, the department shall ensure that any identifiable hospital information disclosed is necessary for the agency's authorized use and that its disclosure meets with state and federal privacy and confidentiality laws, rules and regulations.

History: Laws 1989, ch. 29, § 6; 1994, ch. 59, § 7; 2009, ch. 166, § 2; 2012, ch. 15, § 7; 2015, ch. 121, § 2; 2024, ch. 39, § 21.

24-14A-6.1. Web site; public access; data.

By January 1, 2018, the department shall ensure that the public is provided with access, free of charge, to a user-friendly, searchable and easily accessible web site on which the department shall post and update on a regular basis cost, quality and such other information it publishes pursuant to the Health Information System Act. The web site shall be accessible through the sunshine portal. The department shall adopt and promulgate rules to carry out the provisions of this section.

History: Laws 2015, ch. 121, § 5.

24-14A-7. Health information system; reports.

A. A report in printed format that provides information of use to the general public shall be produced annually. The report shall be made available upon request. The department may make the report available on tape or other electronic format.

B. The department shall provide an annual report of its activities, including health care system statistics, to the legislature. The report shall be submitted by November 15 each year.

History: Laws 1989, ch. 29, § 7; 1994, ch. 59, § 8; 2012, ch. 15, § 8.

24-14A-8. Health information system; confidentiality.

A. Health information collected and disseminated pursuant to the Health Information System Act is strictly confidential and shall not be a matter of public record or accessible to the public except as provided in this section and Sections 24-14A-6 and 24-14A-7 NMSA 1978. No data source shall be liable for damages to any person for having furnished the information to the department.

B. Record-level data provided to the department pursuant to Section 24-14A-6 NMSA 1978 are confidential. The agency that receives record-level data shall not disclose the data except to the extent that they are included in a compilation of aggregate data.

C. The individual forms, electronic information or other forms of data collected by and furnished for the health information system shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. The department may release or disseminate aggregate data, including those data that pertain to a specifically identified hospital or other type of health facility. These data shall be public records if the release of these data does not violate state or federal law relating to the privacy and confidentiality of individually identifiable health information.

History: Laws 1989, ch. 29, § 8; 1994, ch. 59, § 9; 2009, ch. 166, § 3; 2012, ch. 15, § 9; 2015, ch. 121, § 3.

24-14A-9. Health information system; fees.

Except for the annual reports required pursuant to the Health Information System Act, the department may collect a fee of up to one hundred dollars ($100) per hour to offset partially the costs of producing public-use data aggregations or data for single use special studies. Entities contributing data to the system shall be charged reduced rates. Rates shall be established by regulation and shall be reviewed annually. Fees collected pursuant to this section are appropriated to the department to carry out the provisions of the Health Information System Act.

History: Laws 1989, ch. 29, § 9; 1994, ch. 59, § 10; 2012, ch. 15, § 10.

24-14A-10. Health information system; violation; civil penalty.

A. It is unlawful for any person subject to the data reporting requirements of the Health Information System Act and the regulations adopted pursuant to that act not to comply with any of those requirements.

B. A civil action may be brought in the name of the state alleging a violation of Subsection A of this section and a petition may be made to the district court for temporary or permanent injunctive relief. In any such action, if the court finds that a person has wilfully violated Subsection A of this section, upon petition to the court there may be recovered on behalf of the state a civil penalty not to exceed one thousand dollars ($1,000).

History: Laws 1989, ch. 29, § 10.

24-14A-11. Advisory committee.

The secretary of health shall appoint a health information system advisory committee to advise the department in carrying out the provisions of the Health Information System Act. The secretary shall establish the membership and duties of the committee by rule.

History: Laws 2015, ch. 121, § 4.

ARTICLE 14B
Electronic Medical Records

24-14B-1. Short title.

This act [24-14B-1 to 24-14B-10 NMSA 1978] may be cited as the "Electronic Medical Records Act".

History: Laws 2009, ch. 69, § 1.

24-14B-2. Purpose.

The purpose of the Electronic Medical Records Act is to provide for the use, disclosure and protection of electronic medical records.

History: Laws 2009, ch. 69, § 2.

24-14B-3. Definitions.

As used in the Electronic Medical Records Act:

A. "demographic information" means information that identifies the individual who is the subject of the health care information, including the individual's name, date of birth and address and other information necessary to identify the individual, that may be used to identify the individual or that associates the individual with the individual's electronic medical record;

B. "disclose" means to release, transfer, provide, give access to or otherwise divulge in any other manner information outside the entity holding the information;

C. "electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities;

D. "electronic medical record" means an electronic record of an individual patient's health care information that may contain demographic information;

E. "electronic signature" means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by an individual with the intent to sign the record;

F. "health care" means care, services or supplies related to the health of an individual and includes:

(1) preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care and counseling;

(2) services, assessments or procedures that are concerned with the physical or mental condition or functional status of an individual or that affect the structure or function of the body of an individual; and

(3) the sale or dispensing of a drug, a device, a piece of equipment or other item in accordance with a prescription;

G. "health care group purchaser" means a person who is licensed, certified or otherwise authorized or permitted by the New Mexico Insurance Code [Chapter 59A NMSA 1978, except for Articles 30A and 42A] to pay for or purchase health care on behalf of an identified individual or group of individuals, regardless of whether the cost of coverage or services is paid for by the purchaser or the persons receiving coverage or services;

H. "health care information" means any information, whether oral or recorded in any form or medium, related to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual;

I. "health care institution" means an institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business;

J. "health information exchange" means an arrangement among persons participating in a defined secure electronic network service, such as a regional health information organization, that allows the sharing of health care information about individual patients among different health care institutions or unaffiliated providers. The use of an electronic medical record system by a health care provider, by or within a health care institution or by an organized health care arrangement as defined by the federal Health Insurance Portability and Accountability Act of 1996 does not constitute a health information exchange;

K. "information" means data, including text, images, sounds and codes and computer programs, software and databases;

L. "provider" means an individual who is licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession;

M. "record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form;

N. "record locator service" means an information service that contains demographic information and the location of health care information of a specified individual across different health care institutions or unaffiliated providers that participate in the service. The use of an electronic medical record system by a health care provider or by an organized health care arrangement as defined by the federal Health Insurance Portability and Accountability Act of 1996 does not constitute a record locator service; and

O. "treatment" means the provision, coordination or management of health care and related services by one or more providers, including the coordination or management of health care by a provider with a third party; consultation between providers relating to an individual; or the referral of an individual for health care from one provider to another.

History: Laws 2009, ch. 69, § 3.

24-14B-4. Electronic medical records; electronic signatures; legal recognition.

If a law or rule requires a medical record to be in writing, or if a law or rule requires a signature pertaining to a medical record, an electronic medical record or an electronic signature satisfies that law or rule, except for a court rule.

History: Laws 2009, ch. 69, § 4.

24-14B-5. Retention of electronic medical records.

A. If a law or rule requires that a medical record be retained, the requirement is satisfied by retaining an electronic record that:

(1) accurately reflects the medical record; and

(2) remains accessible and is capable of being accurately reproduced for later reference.

B. If a law or rule requires a medical record to be presented or retained in its original form or provides consequences if the medical record is not presented or retained in its original form, that law or rule is satisfied by an electronic medical record retained in accordance with Subsection A of this section.

C. A medical record retained as an electronic medical record in accordance with Subsection A of this section satisfies a law or rule requiring a person to retain a medical record for evidentiary, audit or other purposes.

History: Laws 2009, ch. 69, § 5.

24-14B-6. Use and disclosure of electronic health care information.

A. A provider, health care institution, health information exchange or health care group purchaser shall not use or disclose health care information in an individual's electronic medical record to another person without the consent of the individual except as allowed by state or federal law.

B. A provider, health care institution or health care group purchaser may disclose demographic information and information about the location of an individual's electronic medical records to a record locator service in accordance with state or federal law. A provider or health care institution participating in a health information exchange using a record locator service shall not have access to demographic information, information about the location of the individual's electronic medical records or information in an individual's electronic medical record except in connection with the treatment of the individual or as permitted by the consent of the individual or as otherwise permitted by state or federal law.

C. A record locator service shall maintain an audit log of persons obtaining access to information in the record locator service, which audit log shall contain, at a minimum, information on:

(1) the identity of the person obtaining access to the information;

(2) the identity of the individual whose information was obtained;

(3) the location from which the information was obtained;

(4) the specific information obtained; and

(5) the date that the information was obtained.

D. The audit log shall be made available by a health information exchange on the request of an individual whose health care information is the subject of the audit log; provided, however, that the audit log made available to the individual shall include only information related to that individual. The audit log shall be made available to the requesting individual annually for a fee not to exceed twenty-five cents ($.25) per page as established by the department of health.

E. A record locator service shall provide a mechanism under which individuals may exclude their demographic information and information about the location of their electronic medical records from the record locator service. A person operating a record locator service or a health information exchange that receives an individual's request to exclude all of the individual's information from the record locator service is responsible for removing that information from the record locator service within thirty days. An individual's request for exclusion of information shall be in writing and shall include a waiver of liability for any harm caused by the exclusion of the individual's information.

F. When information in an individual's electronic medical record is requested using a record locator service or a health information exchange:

(1) the requesting provider or health care institution shall warrant that the request is for the treatment of the individual, is permitted by the individual's written authorization or is otherwise permitted by state or federal law; and

(2) the person disclosing the information may rely upon the warranty of the person making the request that the request is for the treatment of the individual, is permitted with the consent of the individual or is otherwise permitted by state or federal law.

G. Notwithstanding any other provision of law, information in an individual's electronic medical record may be disclosed:

(1) to a provider that has a need for information about the individual to treat a condition that poses an immediate threat to the life of any individual and that requires immediate medical attention;

(2) except as provided in the Electronic Medical Records Act, to a record locator service or a health information exchange for the development and operation of the record locator service and the health information exchange; and

(3) to a provider, health care institution or health care group purchaser for treatment, payment or health care operation activities, in compliance with the federal Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated pursuant to that act, and if applicable, in compliance with 42 U.S.C. Section 290dd-2 and the regulations promulgated pursuant to that section.

H. For the purposes of this section, "health care operation activities" includes administrative, financial, legal and quality improvement activities of a covered entity that are necessary to conduct business and to support the core functions of treatment and payment and are limited to the activities listed in the definition of "health care operations" at 45 C.F.R. 164.501.

History: Laws 2009, ch. 69, § 6; 2021, ch. 113, § 1.

24-14B-7. Liability.

If an individual requests to exclude all of the individual's information from the record locator service pursuant to Subsection E of Section 6 [24-14B-6 NMSA 1978] of the Electronic Medical Records Act, the record locator service, health information exchange, health care institution or provider shall not be liable for any harm to the individual caused by the exclusion of the individual's information.

History: Laws 2009, ch. 69, § 7.

24-14B-8. Out-of-state disclosures.

A disclosure otherwise permissible under the Electronic Medical Records Act may be made to providers, health care group purchasers, health care institutions, health information exchanges or record locator services located or operating outside of the state.

History: Laws 2009, ch. 69, § 8.

24-14B-9. Exclusion of certain insurers.

Nothing in the Electronic Medical Records Act shall be construed to apply to a person operating as a property and casualty insurer, workers' compensation insurer, life insurer, long-term care insurer or disability income insurer.

History: Laws 2009, ch. 69, § 9.

24-14B-10. State agency; electronic medical records.

If a state agency requires the use of electronic medical records for any type of health care or health coverage program, the agency shall allow a health care group purchaser, health care institution, health information exchange, provider, record locator service or any other person to use any public, proprietary or open source hardware or software; provided that the hardware or software complies with federal interoperability-certified laws or rules.

History: Laws 2009, ch. 69, § 10.

ARTICLE 14C
Health Care Work Force Data Collection, Analysis and Policy

24-14C-1. Short title.

Chapter 24, Article 14C NMSA 1978 may be cited as the "Health Care Work Force Data Collection, Analysis and Policy Act".

History: Laws 2011, ch. 152, § 1; 2012, ch. 16, § 1.

24-14C-2. Definitions.

As used in the Health Care Work Force Data Collection, Analysis and Policy Act:

A. "board" means any state health care work force licensing or regulatory board, including the New Mexico medical board; the New Mexico board of dental health care; the board of nursing; the board of pharmacy; any other licensing or regulatory board that the chancellor designates; any other health professional licensing board listed in Chapter 61 NMSA 1978; and the university;

B. "chancellor" means the chancellor for health sciences of the university of New Mexico;

C. "database" means the health care work force database created pursuant to the Health Care Work Force Data Collection, Analysis and Policy Act;

D. "ethnicity" means an individual's self-identification or affiliation as either "Hispanic or Latino" or "not Hispanic or Latino" according to cultural, historical, linguistic or religious ties;

E. "New Mexico center for health care workforce analysis" means a state entity that collects, analyzes and reports data regarding the state's health care work force and collaborates with the federal national center for health care workforce analysis pursuant to Section 5103 of the federal Patient Protection and Affordable Care Act;

F. "race" means an individual's self-identification or affiliation with one of the following categories used to identify individuals according to historical or phenotypical characteristics:

(1) American Indian or Alaska Native;

(2) Asian;

(3) Black or African American;

(4) Native Hawaiian or other Pacific Islander;

(5) White; or

(6) a mixture of any of the categories listed in Paragraphs (1) through (5) of this subsection; and

G. "university" means the university of New Mexico.

History: Laws 2011, ch. 152, § 2; 2012, ch. 16, § 2; 2021, ch. 54, § 9.

24-14C-3. Health care work force database; collection of data; housing of data; analysis and reporting.

A. Subject to the availability of state, federal or private foundation funding or other sources of funding, the chancellor shall create and maintain the "health care work force database". The chancellor shall:

(1) enter into agreements with entities to create, house and provide information to state agencies, the legislature and the governor and, as the legislature or governor deems appropriate, any others regarding the state's health care work force; and

(2) seek federal or other sources of funding to create a New Mexico center for health care workforce analysis and to ensure the additional funding and staffing needed to achieve the anticipated outcomes.

B. A board shall supply the university with data pertaining to licensed health care providers for inclusion in the database. A board shall collect a core essential data set at the time of new licensure or licensure renewal, including, but not limited to, a provider's:

(1) demographics, including race, ethnicity and primary and other languages spoken;

(2) practice status, including, but not limited to:

(a) active practices in New Mexico and other locations;

(b) practice type; and

(c) practice settings, such as hospitals, public schools, higher education institutions, clinics and other clinical settings;

(3) education, training and primary and secondary specialties for all health professions as appropriate;

(4) average hours worked per week and the average number of weeks worked per year in the licensed profession over the past twelve months;

(5) percentage of practice engaged in direct patient care and in other activities, such as teaching, research and administration, in the licensed profession;

(6) practice plans for the next five years, including retiring from a health care profession, moving out of state or changing health care work hours; and

(7) professional liability insurance costs and availability as they relate to barriers to practice.

C. The chancellor shall provide to the department of health, in a manner that conforms to department of health rules, access to health care work force data that the university administers pursuant to the Health Care Work Force Data Collection, Analysis and Policy Act.

History: Laws 2011, ch. 152, § 3; 2012, ch. 16, § 3.

24-14C-4. Database establishment and maintenance; delegation.

A. The chancellor may contract and collaborate with a private or public entity to establish and maintain the database, to analyze data collected, to develop reports for

the legislature or the executive branch or to perform other duties to carry out the provisions of the Health Care Work Force Data Collection, Analysis and Policy Act.

B. An entity that establishes, maintains or analyzes data or develops reports by contract pursuant to Subsection A of this section shall provide to the department of health, in a manner that conforms to department of health rules, access to any health care work force data that the entity establishes, maintains, analyzes or reports.

History: Laws 2011, ch. 152, § 4; 2012, ch. 16, § 4.

24-14C-5. Health care work force data collection by boards; mandatory compliance for applicants; reporting by boards; confidentiality of data; rulemaking.

A. An applicant for a license from a board or renewal of a license by a board shall provide the information prescribed by the chancellor pursuant to Subsection C of this section. This section applies to applicants for health professional licensure or renewal of health professional licensure pursuant to Chapter 61 NMSA 1978.

B. A board shall not approve a subsequent application for a license or renewal of a license until the applicant provides the information pursuant to Subsection C of this section.

C. A board shall adopt rules regarding the manner, form and content of reporting data; the consistency of data entry fields used; and the information that an applicant, pursuant to Subsection A of this section, shall provide to a board. At a minimum, the rules shall provide for a core essential data set, including the applicant's:

(1) demographics, including race, ethnicity and primary and other languages spoken;

(2) practice status, including, but not limited to:

(a) active practices in New Mexico and other locations;

(b) practice type; and

(c) practice settings, such as hospital, clinic or other clinical settings;

(3) education, training and primary and secondary specialties;

(4) average hours worked per week and the average number of weeks worked per year in the licensed profession;

(5) percentage of practice engaged in direct patient care and in other activities, such as teaching, research and administration, in the licensed profession; and

(6) practice plans for the next five years, including retiring from the health care profession, moving out of state or changing health care work hours.

D. A board shall report health care work force information collected pursuant to this section to the chancellor.

E. A board shall keep confidential and not release personally identifiable data collected under this section for any person licensed, registered or certified by the board. The provisions of this subsection do not apply to the release of information to a law enforcement agency for investigative purposes or to the release to the chancellor for state health planning purposes. A person with whom the university contracts to perform data collection, storage and analysis shall protect the privacy of that data. The chancellor shall ensure that the responses of applicants shall be kept confidential, including taking special precautions when the identity of an applicant may be ascertained due to the applicant's location or occupation.

F. A board shall promulgate rules as necessary to perform the board's duties pursuant to this section, including rules for collecting, storing and analyzing data in addition to the information required to be collected by the Health Care Work Force Data Collection, Analysis and Policy Act.

History: Laws 2011, ch. 152, § 5; 2012, ch. 16, § 5.

24-14C-6. Health care work force work group; work force data analysis; recruitment planning; strategic plan for improving health care access; work force survey.

The chancellor for health sciences of the university of New Mexico shall convene a health care work force work group that includes representatives of health care consumers; health care providers; organized groups representing physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists and pharmacists; health care work force training institutions; the department of health; the public education department; the higher education department; and the boards. The work group shall:

A. analyze and make recommendations to the legislature regarding incentives to attract qualified individuals, including those from minority groups underrepresented among health care professions, to pursue health care education and practice in New Mexico;

B. develop a short-term plan and a five-year plan to improve health care access, with a draft report on the plans to be submitted to the interim legislative health and human services committee by November 1, 2011. Beginning October 1, 2012, the work group shall make detailed annual reports to the legislative health and human services committee by October 1 of each year;

C. analyze the collected data and make recommendations to the legislature for building healthier communities and improving health outcomes; and

D. devise an electronic survey, designed to be completed by applicants within fifteen minutes, for boards to provide to applicants for licensure or renewal of licensure, which includes questions regarding the information required pursuant to Subsection C of Section 24-14C-5 NMSA 1978 and any other survey questions that the chancellor and the work group deem appropriate.

History: Laws 2011, ch. 152, § 6; 2012, ch. 16, § 6.

ARTICLE 15
Ski Safety

24-15-1. Short title.

Chapter 24, Article 15 NMSA 1978 may be cited as the "Ski Safety Act".

History: 1953 Comp., § 12-16-1, enacted by Laws 1969, ch. 218, § 1; recompiled as 1953 Comp., § 12-28-1, by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 1.

24-15-2. Purpose of act.

A. In order to safeguard life, health, property and the welfare of this state, it is the policy of New Mexico to protect its citizens and visitors from unnecessary hazards in the operation of ski lifts and passenger aerial tramways and to require liability insurance to be carried by operators of ski lifts and tramways. The primary responsibility for the safety of operation, maintenance, repair and inspection of ski lifts and tramways rests with the operators of such devices. The primary responsibility for the safety of the individual skier while engaging in the sport of skiing rests with the skier himself. The state, through the Ski Safety Act, recognizes these responsibilities and duties on the part of the ski area operator and the skier.

B. It is recognized that there are inherent risks in the sport of skiing, which should be understood by each skier and which are essentially impossible to eliminate by the ski area operator. It is the purpose of the Ski Safety Act to define those areas of responsibility and affirmative acts for which ski area operators shall be liable for loss, damage or injury and those risks which the skier or passenger expressly assumes and for which there can be no recovery.

History: 1953 Comp., § 12-16-2, enacted by Laws 1969, ch. 218, § 2; recompiled as 1953 Comp., § 12-28-2, by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 2; 1997, ch. 211, § 1.

24-15-3. Definitions.

As used in the Ski Safety Act:

A. "ski lift" means any device operated by a ski area operator used to transport passengers by single or double reversible tramway, chair lift or gondola lift, T-bar lift, J-bar lift, platter lift or similar device or a fiber rope tow;

B. "passenger" means any person, at any time in the year, who is lawfully using a ski lift or is waiting to embark or has recently disembarked from a ski lift and is in its immediate vicinity;

C. "ski area" means the property owned, permitted, leased or under the control of the ski area operator and administered as a single enterprise within the state;

D. "ski area operator" means any person, partnership, corporation or other commercial entity and its agents, officers, employees or representatives who has operational responsibility for any ski area or ski lift;

E. "skiing" means participating in the sport in which a person slides on snow, ice or a combination of snow and ice while using skis;

F. "skiing area" means all slopes, trails, terrain parks and competition areas, not including any ski lift;

G. "skier" means any person, including a person enrolled in ski school or other class for instruction, who is on skis and present at a skiing area under the control of a ski area operator for the purpose of engaging in the sport of skiing by utilizing the ski slopes and trails and does not include a passenger;

H. "ski slopes and trails" means those areas designated by the ski area operator to be used by skiers for the purpose of participating in the sport of skiing;

I. "ski retention device" means a device designed to help prevent runaway skis; and

J. "skis" means any device used for skiing, including alpine skis, telemark skis, cross-country skis, mono-skis, snowboards, bladerunners, adaptive devices used by disabled skiers, or tubes, sleds or any other device used to accomplish the same or a similar purpose to participate in the sport of skiing.

History: Laws 1969, ch. 218, § 3; 1953 Comp., § 12-16-3; recompiled as 1953 Comp., § 12-28-3 by Laws 1972, ch. 51, § 9; 1978 Comp., § 24-15-3, repealed and reenacted by Laws 1979, ch. 279, § 3; 1997, ch. 211, § 2.

24-15-4. Insurance.

A. Every ski area operator shall file with the department of transportation and keep on file with the department proof of financial responsibility in the form of a current insurance policy in a form approved by the department, issued by an insurance company authorized to do business in the state and conditioned to pay, within the limits of liability prescribed in this section, all final judgments for personal injury or property damage proximately caused by or resulting from negligence of the ski area operator covered by the policy, as such negligence is defined and limited by the Ski Safety Act. The minimum limits of liability insurance to be provided by ski area operators shall be as follows:

SKI SAFETY ACT
LIABILITY INSURANCE
LIMITS OF LIABILITY
REQUIRED MINIMUM COVERAGES
FOR INJURIES, DEATH OR DAMAGES

KIND AND NUMBER OF LIFTS OPERATED	LIMITS FOR BODILY INJURY TO OR DEATH OF ONE PERSON	LIMITS FOR BODILY INJURY TO OR DEATH OF ALL PERSONS INJURED OR KILLED IN ANY ONE ACCIDENT	PROPERTY DAMAGE
Not more than three surface lifts	$ 100,000	$ 300,000	$ 5,000
Not more than three ski lifts, including one or more chair lifts	250,000	500,000	25,000
More than three ski lifts or one or more tramways	500,000	1,000,000	50,000.

B. No ski lift or tramway shall be operated in this state after the effective date of the Ski Safety Act unless a current insurance policy as required by this section is in effect and properly filed with the department of transportation. Each policy shall contain a provision that it cannot be canceled prior to its expiration date without thirty days' written notice of intent to cancel served by registered mail on the insured and on the department.

History: 1953 Comp., § 12-16-4, enacted by Laws 1969, ch. 218, § 4; recompiled as 1953 Comp., § 12-28-4, by Laws 1972, ch. 51, § 9; 1997, ch. 211, § 3; 2023, ch. 100, § 13.

24-15-5. Penalty.

Any operator convicted of operating a ski lift or aerial passenger tramway without having obtained and kept in force an insurance policy as required by the Ski Safety Act

is guilty of a misdemeanor punishable by a fine of not more than five hundred dollars ($500) for each day of illegal operation. The attorney general or the district attorney of the county where the ski area is located has the power to bring proceedings in the district court of the county in which the ski area is located to enjoin the operation of any ski lift or tramway being operated without a current insurance policy, in the amounts prescribed herein, being obtained and kept in force and covering the operator concerned.

History: 1953 Comp., § 12-16-5, enacted by Laws 1969, ch. 218, § 5; recompiled as 1953 Comp., § 12-28-5, by Laws 1972, ch. 51, § 9; 1997, ch. 211, § 4.

24-15-6. Provisions in lieu of others.

Provisions of the Ski Safety Act are in lieu of all other regulations, registration or licensing requirements for ski areas, ski lifts and tramways. Ski lifts and tramways shall not be construed to be common carriers within the meaning of the laws of New Mexico.

History: 1953 Comp., § 12-16-6, enacted by Laws 1969, ch. 218, § 6; recompiled as 1953 Comp., § 12-28-6, by Laws 1972, ch. 51, § 9.

24-15-7. Duties of ski area operators with respect to skiing areas.

Every ski area operator shall have the following duties with respect to the operation of a skiing area:

A. to mark all snow-maintenance vehicles and to furnish such vehicles with flashing or rotating lights, which shall be in operation whenever the vehicles are working or are in movement in the skiing area;

B. to mark with a visible sign or other warning implement the location of any hydrant or similar equipment used in snow-making operations and located on ski slopes and trails;

C. to mark in a plainly visible manner the top or entrance to each slope, trail or area with the appropriate symbol for its relative degree of difficulty, using the symbols established or approved by the national ski areas association; and those slopes, trails or areas which are closed, or portions of which present an unusual obstacle or hazard, shall be marked at the top or entrance or at the point of the obstacle or hazard with the appropriate symbols as are established or approved by the national ski areas association or by the New Mexico ski area operators association;

D. to maintain one or more trail boards at prominent locations at each ski area displaying that area's network of ski trails and slopes with each trail and slope rated in accordance with the symbols and containing a key to the symbols;

E. to designate by trail board or otherwise at the top of or entrance to the subject trail or slope which trails or slopes are open or closed;

F. to place or cause to be placed, whenever snow-maintenance vehicles or snow-making operations are being undertaken upon any trail or slope while such trail or slope is open to the public, a conspicuous notice to that effect at or near the top or entrance of such trail or slope;

G. to provide ski patrol personnel trained in first aid, which training meets at least the requirements of the national ski patrol outdoor emergency care course, and also trained in winter rescue and toboggan handling to serve the anticipated number of injured skiers and to provide personnel trained for the evacuation of passengers from stalled aerial ski lifts. A first aid room or building shall be provided with adequate first aid supplies, and properly equipped rescue toboggans shall be made available at all reasonable times at the top of ski slopes and trails to transport injured skiers from the ski slopes and trails to the first aid room;

H. to post notice of the requirements of the Ski Safety Act concerning the use of ski retention devices;

I. to warn of or correct particular hazards or dangers known to the operator where feasible to do so; and

J. to warn of snowmobiles or all-terrain vehicles (ATV's) operated on the ski slopes or trails with at least one lighted headlamp, one lighted red tail lamp, a brake system and a fluorescent flag that is at least forty square inches and is mounted at least six feet above the bottom of the tracks or tires.

History: Laws 1969, ch. 218, § 7; 1953 Comp., § 12-16-7; recompiled as 1953 Comp., § 12-28-7 by Laws 1972, ch. 51, § 9; 1978 Comp., § 24-15-7, repealed and reenacted by Laws 1979, ch. 279, § 4; 1997, ch. 211, § 5.

24-15-8. Duties of ski area operators with respect to ski lifts.

Every ski area operator has the duty to operate, repair and maintain all ski lifts in safe condition. The ski area operator, prior to December 1 of each year, shall certify to the department of transportation the policy number and name of the company providing liability insurance for the ski area, the date of the ski lift inspections and the name of the person making those inspections.

History: Laws 1969, ch. 218, § 8; 1953 Comp., § 12-16-8; recompiled as 1953 Comp., § 12-28-8 by Laws 1972, ch. 51, § 9; 1978 Comp., § 24-15-8, repealed and reenacted by Laws 1979, ch. 279, § 5; 2023, ch. 100, § 14.

24-15-9. Duties of passengers.

Every passenger shall have the duty to conduct himself carefully and not to:

A. board or embark upon or disembark from a ski lift except at an area designated for such purpose;

B. drop, throw or expel any object from a ski lift;

C. do any act which shall interfere with the running or operation of a ski lift;

D. use any ski lift unless the passenger has the ability to use it safely without any instruction on its use by the ski area operator or requests and receives instruction before boarding the ski lift;

E. willfully or negligently engage in any type of conduct which contributes to or causes injury to any person;

F. embark on a ski lift without the authority of the ski area operator;

G. use any ski lift without engaging such safety or restraining devices as may be provided; or

H. wear skis without properly securing ski retention devices; or

I. use a ski lift while intoxicated or under the influence of any controlled substance.

History: 1978 Comp., § 24-15-9, enacted by Laws 1979, ch. 279, § 6.

24-15-10. Duties of the skiers.

A. It is recognized that skiing as a recreational sport is inherently hazardous to skiers, and it is the duty of each skier to conduct himself carefully.

B. A person who takes part in the sport of skiing accepts as a matter of law the dangers inherent in that sport insofar as they are obvious and necessary. Each skier expressly assumes the risk of and legal responsibility for any injury to person or property which results from participation in the sport of skiing, in the skiing area, including any injury caused by the following: variations in terrain; surface or subsurface snow or ice conditions; bare spots; rocks, trees or other forms of forest growth or debris; lift towers and components thereof, pole lines and snow-making equipment which are plainly visible or are plainly marked in accordance with the provisions of Section 24-15-7 NMSA 1978; except for any injuries to persons or property resulting from any breach of duty imposed upon ski area operators under the provisions of Sections 24-15-7 and 24-15-8 NMSA 1978. Therefore, each skier shall have the sole individual responsibility for knowing the range of his own ability to negotiate any slope or trail, and it shall be the duty of each skier to ski within the limits of the skier's own ability, to maintain reasonable control of speed and course at all times while skiing, to heed all posted warnings, to ski

only on a skiing area designated by the ski area operator and to refrain from acting in a manner which may cause or contribute to the injury of anyone.

C. Responsibility for collisions by any skier while actually skiing, with any person or object, shall be solely that of each individual involved in the collision, except where an employee, agent or officer of the ski area operator is personally involved in a collision while in the course and scope of his employment or where a collision resulted from any breach of duty imposed upon a ski area operator under the provisions of Sections 24-15-7 or 24-15-8 NMSA 1978. Each skier has the duty to stay clear of and avoid collisions with snow-maintenance equipment, all-terrain vehicles and snowmobiles marked in compliance with the provisions of Subsections A and J of Section 24-15-7 NMSA 1978, all other vehicles, lift towers, signs and any other structures, amenities or equipment on the ski slopes and trails or in the skiing area.

D. No person shall:

(1) place any object in the skiing area or on the uphill track of any ski lift which may cause a passenger or skier to fall;

(2) cross the track of any T-bar lift, J-bar lift, platter lift or similar device or a fiber rope tow, except at a designated location;

(3) when injured while skiing or using a ski lift or, while skiing, when involved in a collision with any skier or object in which an injury results, leave the ski area before giving his name and current address to the ski area operator, or representative or employee of the ski area operator, and the location where the injury or collision occurred and the circumstances thereof; provided, however, in the event a skier fails to give the notice required by this paragraph, a court, in determining whether or not such failure constitutes a violation of the Ski Safety Act, may consider the reasonableness or feasibility of giving such notice; or

(4) use a ski lift, skiing area, slopes or trails while intoxicated or under the influence of any controlled substance.

E. No skier shall fail to wear retention straps or other ski retention devices to help prevent runaway skis.

F. Any skier upon being injured shall indicate, to the ski patrol personnel offering first aid treatment or emergency removal to a first aid room, his acceptance or rejection of such services as provided by the ski area operator. If such service is not refused or if the skier is unable to indicate his acceptance or rejection of such service, the acceptance of the service is presumed to have been accepted by the skier. Such acceptance shall not constitute a waiver of any action for negligent provision of the service by the ski patrol personnel.

History: 1978 Comp., § 24-15-10, enacted by Laws 1979, ch. 279, § 7; 1997, ch. 211, § 6.

24-15-11. Liability of ski area operators.

Any ski area operator shall be liable for loss or damages caused by the failure to follow the duties set forth in Sections 24-15-7 and 24-15-8 NMSA 1978 where the violation of duty is causally related to the loss or damage suffered, and shall continue to be subject to liability in accordance with common-law principles of vicarious liability for the willful or negligent actions of its principals, agents or employees which cause injury to a passenger, skier or other person. The ski area operator shall not be liable to any passenger or skier acting in violation of his duties as set forth in Sections 24-15-9 and 24-15-10 NMSA 1978 where the violation of duty is causally related to the loss or damage suffered.

History: 1978 Comp., § 24-15-11, enacted by Laws 1979, ch. 279, § 8.

24-15-12. Liability of passengers.

Any passenger shall be liable for loss or damages resulting from violations of the duties set forth in Section 24-15-9 NMSA 1978, and shall not be able to recover from the ski area operator for any losses or damages where the violation of duty is causally related to the loss or damage suffered.

History: 1978 Comp., § 24-15-12, enacted by Laws 1979, ch. 279, § 9.

24-15-13. Liability of skiers.

Any skier shall be liable for loss or damages resulting from violations of the duties set forth in Section 24-15-10 NMSA 1978, and shall not be able to recover from the ski area operator for any losses or damages where the violation of duty is causally related to the loss or damage suffered.

History: 1978 Comp., § 24-15-13, enacted by Laws 1979, ch. 279, § 10.

24-15-14. Limitation of actions; notice of claim.

A. Unless a ski area operator is in violation of the Ski Safety Act, with respect to the skiing area and ski lifts, and the violation is a proximate cause of the injury complained of, no action shall lie against such ski area operator by any skier or passenger or any representative of a skier or passenger. This prohibition shall not prevent the bringing of an action against a ski area operator for damages arising from injuries caused by negligent operation, maintenance or repair of the ski lift.

B. No suit or action shall be maintained against any ski area operator for injuries incurred as a result of the use of a ski lift or ski area unless the same is commenced within three years of the time of the occurrence of the injuries complained of.

History: 1978 Comp., § 24-15-14, enacted by Laws 1979, ch. 279, § 11.

ARTICLE 15A
Search and Rescue

24-15A-1. Short title.

This act [24-15A-1 to 24-15A-6 NMSA 1978] may be cited as the "Search and Rescue Act".

History: 1978 Comp., § 24-15A-1, enacted by Laws 1978, ch. 107, § 1.

24-15A-2. Purpose of act.

It is the purpose of the Search and Rescue Act:

A. to prepare, organize and coordinate efforts of federal, state and local governmental agencies and volunteer organizations for prompt and efficient search, location, rescue, recovery, care and treatment of persons lost, entrapped or in physical danger;

B. to further coordinate national and state search and rescue agreements; and

C. to develop and administer a statewide plan for search and rescue.

History: 1978 Comp., § 24-15A-2, enacted by Laws 1978, ch. 107, § 2.

24-15A-3. Definitions.

As used in the Search and Rescue Act:

A. "search and rescue" or "SAR" means the employment, coordination and utilization of available resources and personnel in locating, relieving the distress and preserving the lives of and removing survivors from the site of a disaster, emergency or hazard to a place of safety in the case of lost, stranded, entrapped or injured persons;

B. "board" means the state search and rescue review board;

C. "AFRCC" means the air force rescue coordination center, which is the federal agency responsible for coordinating federal SAR activities within the inland region pursuant to the national search and rescue plan;

D. "state SAR control agency" means the department of public safety;

E. "state SAR mission initiator" means the New Mexico state police officer so appointed and SAR trained;

F. "state SAR resource officer" means the official located within the department of public safety responsible for coordinating SAR resources and administering the state SAR plan;

G. "field coordinator" means a person certified by the board with special training and expertise responsible for the efficient organization and conduction of a SAR mission;

H. "civil air patrol" means the civil air patrol division of the department of military affairs and an air force auxiliary responsible for coordinating air searches which are authorized by the AFRCC;

I. "mission" means each separate group effort in the employment, direction and guidance of personnel and facilities in searching for and rendering aid to persons lost or in distress;

J. "chief" means the chief of the New Mexico state police division of the department of public safety; and

K. "director" means the director of the technical and emergency support division of the department of public safety.

History: 1978 Comp., § 24-15A-3, enacted by Laws 1978, ch. 107, § 3; 1979, ch. 202, § 8; 1989, ch. 204, § 16.

24-15A-4. State search and rescue resource officer; position created.

A. The position of "state search and rescue resource officer" is created within the department of public safety.

B. The state search and rescue resource officer shall be a noncommissioned employee.

C. The state search and rescue resource officer shall be the chief administrator of the state search and rescue plan.

History: 1978 Comp., § 24-15A-3, enacted by Laws 1978, ch. 107, § 4; 1979, ch. 202, § 8; 1989, ch. 204, § 17.

24-15A-5. State search and rescue resource officer; powers and duties.

The state search and rescue resource officer shall, with the approval of the director:

A. compile, maintain and disseminate an inventory of resources available in the state;

B. compile, maintain and disseminate rosters of persons, agencies and organizations available for search and rescue purposes;

C. develop a training program for the certification of search and rescue instructors and, by regulation, adopt a system of certification of search and rescue persons;

D. act as contact agent for the state in search and rescue matters;

E. develop and periodically review requirements for insurance coverage for search and rescue volunteers;

F. coordinate the training of mission initiators and field coordinators;

G. maintain records of missions at the state SAR control agency; and

H. submit to the risk management division of the general services department claims for coverage pursuant to Section 13-5-1 NMSA 1978 for damage to personal property of volunteers incurred in the course and scope of an authorized search and rescue mission.

History: 1978 Comp., § 24-15A-5, enacted by Laws 1978, ch. 107, § 5; 1979, ch. 202, § 10; 1989, ch. 204, § 18; 2019, ch. 234, § 1.

24-15A-6. State search and rescue review board created; membership; duties and responsibilities; terms.

A. There is created a policy advisory committee, to be known as the "state search and rescue review board", whose duty it is to evaluate the operation of the New Mexico search and rescue plan; evaluate problems of specific missions; and make findings of fact and recommendations to the chief, director and other appropriate authorities. The board shall consist of the state search and rescue resource officer, who shall be a nonvoting member, and seven members appointed by the governor as follows:

(1) the secretary of public safety or his designee;

(2) the secretary of health or his designee;

(3) a representative of the civil air patrol division of the department of military affairs;

(4) a representative of the New Mexico emergency services council;

(5) a member certified as a search and rescue person;

(6) a member of the New Mexico sheriff's association;

(7) the chief of the New Mexico state police division of the department of public safety or his designee; and

(8) a member of the general public who shall act as chairman of the board and who shall vote only in case of a tie.

B. The board shall have the duty and responsibility to:

(1) meet at least quarterly or more frequently at the call of the chairman;

(2) evaluate the operation and effectiveness of the state SAR plan and make recommendations to the director;

(3) evaluate the operational effectiveness of specific missions, make findings of fact and recommendations to the chief and other appropriate authorities for the elimination of problems and the improvement of overall conduct of the mission;

(4) hold hearings and invite individuals to appear and testify before the board and reimburse such witnesses for travel expenses incurred;

(5) prepare a report for the attorney general's office in cases of victim hospitalization or death; and

(6) with the approval of the chief, certify field coordinators and confirm certification of SAR persons.

C. The governor shall appoint the seven appointed members for staggered terms of three years each made in such a manner that the terms of not more than three members expire on January 1 of 1979, 1980 and 1981. Thereafter, appointments shall be made so that the terms of not more than three members expire on January 1 of each year. Vacancies shall be filled by appointment by the governor for the unexpired term. Any member of the board who misses more than two consecutive meetings shall automatically be removed as a member of the board.

History: 1978 Comp., § 24-15A-6, enacted by Laws 1978, ch. 107, § 6; 1979, ch. 202, § 11; 1983, ch. 296, § 28; 1989, ch. 204, § 19; 1993, ch. 15, § 1.

ARTICLE 16
Dee Johnson Clean Indoor Air

24-16-1. Short title.

Chapter 24, Article 16 NMSA 1978 may be cited as the "Dee Johnson Clean Indoor Air Act".

History: Laws 1985, ch. 85, § 1; 2007, ch. 20, § 1.

24-16-2. Declaration of policy and intent; public health.

The legislature finds and declares that the smoking of tobacco, or any other weed or plant, is a positive danger to health and a health hazard to those who are present in enclosed places and that smoking in such areas should be confined to designated smoking areas. The legislature further declares its intention to protect the public health from such hazards in public places and places of employment without imposing exorbitant costs on persons in management and control of the places subject to the [Dee Johnson] Clean Indoor Air Act. It is not the intent of the legislature to preempt the field of regulation of smoking in public from the enactment of ordinances by local governing bodies which are not inconsistent with the [Dee Johnson] Clean Indoor Air Act.

History: Laws 1985, ch. 85, § 2.

24-16-3. Definitions.

As used in the Dee Johnson Clean Indoor Air Act:

A. "bar" means an establishment that is devoted to the selling or serving of alcoholic beverages for consumption by patrons on the premises and in which the serving of food is only incidental to the consumption of those beverages, including taverns, nightclubs, cocktail lounges and cabarets;

B. "cigar bar" means an establishment that:

(1) is a bar as defined in Subsection A of this section; and

(2) is engaged in the business of selling cigars for consumption by patrons on the premises and generates ten percent or more of its total annual gross revenue or at least ten thousand dollars ($10,000) in annual sales from the sale of cigars, not including any sales from vending machines. A cigar bar that fails to generate at least ten percent of its total annual sales from the sale of cigars in the calendar year after December 31, 2006, not including sales from vending machines, shall not be defined as a cigar bar and shall not thereafter be known as such regardless of sales figures. A

cigar bar shall agree to provide adequate information to demonstrate to the state's satisfaction compliance with this definition;

C. "department" means the department of health;

D. "designated outdoor smoking area" means an area where smoking may be permitted, designated by an employer or manager, outside an indoor workplace or indoor public place; provided that the following conditions are maintained:

(1) smoking shall not be permitted near any building entrance, including a door, window or ventilation system of any facility where smoking is prohibited under the provisions of the Dee Johnson Clean Indoor Air Act, so as to prevent secondhand smoke from entering the indoor workplace or indoor public place; and

(2) employees or members of the general public are not required to walk through the smoking area to gain entrance to the indoor workplace or indoor public place;

E. "e-cigarette" means a product containing or delivering nicotine or another substance intended for human consumption that can be used by a person in any manner for the purpose of inhaling vapor or aerosol from the product, including a device, whether manufactured, distributed, marketed or sold as an e-cigarette, e-cigar, e-pipe, e-hookah or vape pen or under another product name or descriptor;

F. "employer" means an individual, a partnership, a corporation or the state or a political subdivision of the state that employs the services of one or more individuals;

G. "enclosed" means an interior space predominantly or totally bounded on all sides and above by physical barriers, regardless of whether such barriers consist of or include uncovered openings, screened or otherwise partially covered openings or open or closed windows;

H. "indoor public place" means the enclosed area within a governmental or nongovernmental place to which the public is invited or in which the public is permitted regardless of whether work or public business, meetings or hearings occur at any given time;

I. "indoor workplace" means an enclosed place where one or more persons engage in work, including lobbies, reception areas, offices, conference and meeting rooms, employee cafeterias and lunchrooms, break rooms and employee lounges, classrooms, auditoriums, hallways, stairways, waiting areas, elevators and restrooms and includes all indoor workplaces and enclosed parts regardless of whether work occurs at any given time;

J. "private club" means an organization, whether incorporated or not, that is the owner, lessee or occupant of a building or portion thereof used exclusively for the

organization's purposes at all times, that is operated solely for recreational, fraternal, social, patriotic, political, benevolent or athletic purposes, but not for pecuniary gain, and that only sells alcoholic beverages incidental to its operation. The organization shall have bylaws or a constitution to govern its activities and shall have been granted an exemption as a club under the provisions of Section 501 of the Internal Revenue Code of 1986, as amended;

K. "retail tobacco store" means a retail store, used primarily for the sale of tobacco products, including e-cigarettes, and accessories and in which the sale of other products is merely incidental, including smoke shops, cigar shops or hookah lounges, and does not include establishments that offer for sale alcoholic beverages for consumption by patrons on the premises;

L. "secondhand smoke" means:

(1) smoke emitted from inhaling from, exhaling from, burning, carrying or holding:

(a) a lighted or heated cigar, cigarette, hookah or pipe; or

(b) any other lighted or heated tobacco or plant product intended for inhalation, including cannabis, whether natural or synthetic; or

(2) the aerosol or vapor emitted from inhaling or exhaling or any other use of an e-cigarette;

M. "smokefree area" means a building or other enclosed space where smoking is prohibited;

N. "smoking" means:

(1) inhaling from, exhaling from, burning, carrying or holding:

(a) a lighted or heated cigar, cigarette, hookah or pipe; or

(b) any other lighted or heated tobacco or plant product intended for inhalation, including cannabis, whether natural or synthetic; or

(2) any use of an e-cigarette that creates an aerosol or vapor;

O. "smoking-permitted area" means a building or other enclosed space where smoking may be permitted; provided that secondhand smoke does not infiltrate any area where smoking is prohibited pursuant to the Dee Johnson Clean Indoor Air Act; and

P. "standalone building" means a building whose heating, air conditioning and ventilation system services only that building.

History: Laws 1985, ch. 85, § 3; 2007, ch. 20, § 2; 2019, ch. 128, §1.

24-16-4. Smoking prohibited.

A. It is unlawful for a person to smoke in any indoor workplace or indoor public place or in buses, taxicabs or other means of public transit not specifically exempted pursuant to the Dee Johnson Clean Indoor Air Act.

B. No part of the state capitol or capitol north shall be designated as a smoking-permitted area.

History: Laws 1985, ch. 85, § 4; 1999, ch. 250, § 1; 2002, ch. 2, § 1; 2007, ch. 20, § 3.

24-16-5. Repealed.

History: Laws 1985, ch. 85, § 5; repealed by Laws 2007, ch. 20, § 13.

24-16-6. Repealed.

History: Laws 1985, ch. 85, § 6; repealed by Laws 2007, ch. 20, § 13.

24-16-7. Repealed.

History: Laws 1985, ch. 85, § 7; repealed by Laws 2007, ch. 20, § 13.

24-16-8. Repealed.

History: Laws 1985, ch. 85, § 8; repealed by Laws 2007, ch. 20, § 13.

24-16-9. Repealed.

History: Laws 1985, ch. 85, § 9; repealed by Laws 2007, ch. 20, § 13.

24-16-10. Repealed.

History: Laws 1985, ch. 85, § 10; repealed by Laws 2007, ch. 20, § 13.

24-16-11. Repealed.

History: Laws 1985, ch. 85, § 11; repealed by Laws 2007, ch. 20, § 13.

24-16-12. Smoking-permitted areas.

Notwithstanding any other provision of the Dee Johnson Clean Indoor Air Act, smoking-permitted areas include the following:

A. a private residence, unless it is used commercially to provide child care, adult care or health care or any combination of those activities;

B. a retail tobacco store; provided that, for a retail tobacco store established on or after the effective date of this 2019 act, the store shall be located in a standalone building;

C. a cigar bar; provided that, for a cigar bar established on or after June 14, 2019, the bar shall be located in a standalone building;

D. the facilities of a tobacco manufacturing company licensed by the United States to manufacture tobacco products that are operated by the company in its own name and that are used exclusively by the company in its business of manufacturing, marketing or distributing its tobacco products; provided that secondhand smoke does not infiltrate other indoor workplaces or other indoor public places where smoking is otherwise prohibited under the Dee Johnson Clean Indoor Air Act;

E. a state-licensed gaming facility, casino or bingo parlor;

F. designated outdoor smoking areas;

G. private clubs;

H. hotel and motel rooms that are rented to guests and are designated as smoking-permitted rooms; provided that not more than ten percent of rooms rented to guests in a hotel or motel may be so designated;

I. a site that is being used in connection with the practice of cultural or ceremonial activities by Native Americans and that is in accordance with the federal American Indian Religious Freedom Act, 42 U.S.C. 1996 and 1996a;

J. a theatrical stage or a motion picture or television production set when it is necessary for performers to smoke as part of the production; and

K. an indoor or outdoor cannabis consumption area pursuant to the Cannabis Regulation Act [Chapter 26, Article 2C NMSA 1978].

History: Laws 2007, ch. 20, § 4; 2019, ch. 128, § 2; 2021 (1st S.S.), ch. 4, § 57.

24-16-13. Prohibition of smoking near entrances, windows and ventilation systems.

Smoking is prohibited near entrances, windows and ventilation systems of all workplaces and public places where smoking is prohibited by the Dee Johnson Clean Indoor Air Act. An individual who owns, manages, operates or otherwise controls the use of a premises subject to the provisions of the Dee Johnson Clean Indoor Air Act shall establish a smokefree area that extends a reasonable distance from any entrances, windows and ventilation systems to any enclosed areas where smoking is prohibited. The reasonable distance shall be a distance sufficient to ensure that persons entering or leaving the building or facility shall not be subjected to breathing secondhand smoke and to ensure that secondhand smoke does not enter the building or facility through entrances, windows, ventilation systems or any other means.

History: Laws 2007, ch. 20, § 5; 2019, ch. 128, § 3.

24-16-14. Responsibilities of employers.

A. Employers shall provide that their places of employment meet the requirements of the Dee Johnson Clean Indoor Air Act.

B. An employer shall adopt, implement, post and maintain a written smoking policy pursuant to the Dee Johnson Clean Indoor Air Act.

History: Laws 2007, ch. 20, § 6.

24-16-15. Posted smokefree and smoking-permitted areas.

A. To advise persons of the existence of smokefree areas or smoking-permitted areas, signs shall be posted as follows:

(1) for each indoor workplace or indoor public place where smoking is prohibited pursuant to the Dee Johnson Clean Indoor Air Act, a "NO SMOKING" sign shall be posted where it is clear, conspicuous and easily legible at each public entrance. Posting of "NO SMOKING" signs is the responsibility of the owner, operator, manager or other person having control of the indoor workplace or indoor public place; and

(2) for each indoor workplace or indoor public place where smoking is permitted pursuant to the Dee Johnson Clean Indoor Air Act, a "SMOKING PERMITTED" sign shall be posted where it is clear, conspicuous and easily legible at each public entrance, unless an owner, operator or manager chooses to prohibit smoking in all or part of an indoor workplace or indoor public place where smoking is otherwise permitted.

B. Nothing in the Dee Johnson Clean Indoor Air Act shall be construed so as to require the posting of signs at a residence, except during the hours of business operation while it is being used commercially to provide child care, adult care or health care or any combination of those activities.

History: Laws 2007, ch. 20, § 7.

24-16-16. Enforcement.

A. The local fire, police or sheriff's department with appropriate jurisdiction over the location where a violation of the provisions of the Dee Johnson Clean Indoor Air Act occurs shall enforce that act by issuance of a citation.

B. A person may register a complaint regarding an alleged violation pursuant to the Dee Johnson Clean Indoor Air Act to initiate enforcement of that act with the department or the local fire, police or sheriff's department.

C. The designated enforcement agencies may inspect an establishment for compliance with the Dee Johnson Clean Indoor Air Act.

History: Laws 2007, ch. 20, § 8.

24-16-17. Violations.

It is unlawful for a person who owns, manages, operates or otherwise controls the use of premises subject to regulation under the Dee Johnson Clean Indoor Air Act to violate its provisions. The owner, manager or operator of premises subject to regulation under the Dee Johnson Clean Indoor Air Act shall not be subject to a penalty if a person on the premises is in violation of the Dee Johnson Clean Indoor Air Act as long as the owner, manager or operator has posted signs, implemented the appropriate policy and informed the person that the person is in violation of the Dee Johnson Clean Indoor Air Act.

History: Laws 2007, ch. 20, § 9.

24-16-18. Penalties.

A person eighteen years of age or older who violates a provision of the Dee Johnson Clean Indoor Air Act is subject to:

A. a fine not to exceed one hundred dollars ($100) for the first violation of that act;

B. a fine not to exceed two hundred dollars ($200) for the second violation of that act within any consecutive twelve-month period of the first violation; and

C. a fine not to exceed five hundred dollars ($500) for the third and each subsequent violation of that act within any consecutive twelve-month period of a previous violation.

History: Laws 2007, ch. 20, § 10.

24-16-19. Nonretaliation; nonwaiver.

A. A person or employer shall not discharge, refuse to hire or in any manner retaliate against an employee, applicant for employment or patron because that employee, applicant or patron exercises any rights afforded by the Dee Johnson Clean Indoor Air Act or reports or attempts to prosecute a violation of that act.

B. An employee who works in a setting where an employer allows smoking does not waive or otherwise surrender any legal rights the employee may have against the employer or any other party.

History: Laws 2007, ch. 20, § 11.

24-16-20. Explicit nonpreemption.

Nothing in the Dee Johnson Clean Indoor Air Act shall be construed to preempt or in any manner preclude specific provisions of a county or municipal smoking ordinance; provided that the smokefree provisions of such a county or municipal ordinance are inclusive of all minimum standards and provisions for smokefree areas within the Dee Johnson Clean Indoor Air Act.

History: Laws 2007, ch. 20, § 12.

ARTICLE 17
Continuing Care

24-17-1. Short title.

Chapter 24, Article 17 NMSA 1978 may be cited as the "Continuing Care Act".

History: Laws 1985, ch. 102, § 1; 2010, ch. 88, § 1.

24-17-2. Findings and purpose.

A. The legislature finds that continuing care communities are an important and growing alternative for the provision of long-term residential, social and health maintenance needs for the elderly; however, the legislature also finds that severe consequences to residents may result when a provider becomes insolvent or unable to provide responsible care.

B. The purpose of the Continuing Care Act is to provide for disclosure and the inclusion of certain information in continuing care contracts in order that residents may make informed decisions concerning continuing care; to provide protection for residents; and to ensure the solvency of communities.

History: Laws 1985, ch. 102, § 2; 2010, ch. 88, § 2.

24-17-3. Definitions.

As used in the Continuing Care Act:

A. "affiliate" means a person having a five percent or greater interest in a provider;

B. "community" means a retirement home, retirement community, home for the aged or other place that undertakes to provide continuing care;

C. "continuing care" means furnishing, pursuant to a contract that requires entrance or advance fees and service or periodic fees, independent-living and health or health-related services. Entrance or advanced fees do not include security or damage deposit fees that amount to less than three months' service or periodic fees. These services may be provided in the community, in the resident's independent living unit or in another setting, designated by the continuing care contract, to an individual not related by consanguinity or affinity to the provider furnishing the care. The services include, at a minimum, priority access to a nursing facility or hospital either on site or at a site designated by the continuing care contract;

D. "continuing care contract" means an agreement by a provider to furnish continuing care to a resident;

E. "liquid reserves" means cash or other assets that are available within sixty days to satisfy a community's expenses and that do not include real property or interests in real property;

F. "net operating expenses" means the total costs of operating a community, including taxes and insurance but not including amortization, depreciation or long-term debt service;

G. "person" means an individual, corporation, partnership, trust, association or other legal entity;

H. "priority access to a nursing facility or hospital" means that a nursing facility or hospital services the residents of independent living units or that there is a promise of such health care or health-related services being available in the future;

I. "provider" means the owner or manager of a community that provides, or offers to provide, continuing care;

J. "resident" means, unless otherwise specified, an actual or prospective purchaser of, nominee of or subscriber to a continuing care contract;

K. "type A" agreement means an extensive entrance-fee contract that includes housing, residential services, amenities and unlimited specific health-related services with little or no substantial increase in monthly payments, except to cover normal operating costs and inflation adjustments;

L. "type B" agreement means a modified entrance-fee contract that includes housing, residential services, amenities and a specific amount of health care with no substantial increase in monthly payments, except to cover normal operating costs and inflation adjustments. After the specified amount of health care is used, persons served pay either a discounted rate or the full per diem rates for required health care services; and

M. "unit" means the living quarters that a resident buys, leases or has assigned as part of the continuing care contract.

History: Laws 1985, ch. 102, § 3; 1991, ch. 263, § 8; 2005, ch. 215, § 1; 2010, ch. 88, § 3.

24-17-4. Disclosure.

A. A provider shall furnish a current annual disclosure statement that meets the requirements set forth in Subsection B of this section and the aging and long-term services department's and attorney general's consumer's guide to continuing care communities to each actual resident and to a prospective resident at least seven days before the provider enters into a continuing care contract with the prospective resident, or prior to the prospective resident's first payment, whichever occurs first. For the purposes of this subsection, the obligation to furnish information to each actual resident shall be deemed satisfied if a copy of the disclosure statement and the consumer's guide is given to the residents' association, if there is one, and a written message has been delivered to each actual resident, stating that personal copies are available upon request.

B. The disclosure statement provided pursuant to Subsection A of this section shall include:

(1) a brief narrative summary of the contents of the disclosure statement written in plain language;

(2) the name and business address of the provider;

(3) if the provider is a partnership, corporation or association, the names, addresses and duties of its officers, directors, trustees, partners or managers;

(4) the name and business address of each of the provider's affiliates;

(5) a statement as to whether the provider or any of its officers, directors, trustees, partners, managers or affiliates, within ten years prior to the date of application:

(a) was convicted of a felony, a crime that if committed in New Mexico would be a felony or any crime having to do with the provision of continuing care;

(b) has been held liable or enjoined in a civil action by final judgment, if the civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property;

(c) had a prior discharge in bankruptcy or was found insolvent in any court action; or

(d) had a state or federal license or permit suspended or revoked or had any state, federal or industry self-regulatory agency commence an action against the provider or any of its officers, directors, trustees, partners, managers or affiliates and the result of such action;

(6) the name and address of any person whose name is required to be provided in the disclosure statement who owns any interest in or receives any remuneration from, either directly or indirectly, any other person providing or expected to provide to the community goods, leases or services with a real or anticipated value of five hundred dollars ($500) or more and the name and address of the person in which such interest is held. The disclosure shall describe such goods, leases or services and the actual or probable cost to the community or provider and shall describe why such goods, leases or services should not be purchased from an independent entity;

(7) the name and address of any person owning land or property leased to the community and a statement of what land or property is leased;

(8) a statement as to whether the provider is, or is associated with, a religious, charitable or other organization and the extent to which the associate organization is responsible for the financial and contractual obligations of the provider or community;

(9) the location and description of real property being used or proposed to be used in connection with the community's contracts to furnish care;

(10) a statement as to the community's or corporation's liquid reserves to assure payment of debt obligations and an ongoing ability to provide services to residents. The statement shall also include a description of the community's or corporation's reserves, including a specific explanation as to how the community or corporation intends to comply with the requirements of Section 24-17-6 NMSA 1978;

(11) for communities that provide type A and type B agreements:

(a) a summary of a comprehensive actuarial analysis within the last five years; and

(b) an annual future-service obligation calculation by an actuary who is a member of the American academy of actuaries and who is experienced in analyzing continuing care communities;

(12) an audited financial statement and an audit report prepared in accordance with generally accepted accounting principles applied on a consistent basis and certified by a certified public accountant, including an income statement or statement of activities, a cash-flow statement or sources and application of funds statement and a balance sheet as of the end of the provider's last fiscal year. The balance sheet should accurately reflect the deferred revenue balance, including entrance fees and any other prepaid services, and should include notes describing the community's long-term obligations and identifying all the holders of mortgages and notes;

(13) a sample copy of the contract used by the provider; and

(14) a list of documents and other information available upon request, including:

(a) a copy of the Continuing Care Act;

(b) if the provider is a corporation, a copy of the articles of incorporation; if the provider is a partnership or other unincorporated association, a copy of the partnership agreement, articles of association or other membership agreement; and if the provider is a trust, a copy of the trust agreement or instruments;

(c) resumes of the provider and its officers, directors, trustees, partners or managers;

(d) a copy of lease agreements between the community and any person owning land or property leased to the community;

(e) information concerning the location and description of other properties, both existing and proposed, of the provider in which the provider owns any interest and on which communities are or are intended to be located and the identity of previously owned or operated communities;

(f) a copy of the community's policies and procedures; and

(g) other data, financial statements and pertinent information with respect to the provider or community, or its directors, trustees, members, managers, branches, subsidiaries or affiliates, that a resident requests and that is reasonably necessary in order for the resident to determine the financial status of the provider, its sole member and the community and the management capabilities of the managers and owners,

including the most recent audited financial statements of comparable communities owned, managed or developed by the provider, its sole member or its principal.

C. Each year, within one hundred eighty days after the end of the community's fiscal year, the provider shall furnish to actual residents the disclosure statement as outlined in this section. For purposes of this subsection, the obligation to furnish the required information to residents shall be deemed satisfied if the information is given to the residents' association, if there is one, and a written message has been delivered to each resident, stating that personal copies of the information are available upon request.

History: Laws 1985, ch. 102, § 4; 1991, ch. 263, § 9; 2005, ch. 215, § 2; 2010, ch. 88, § 4; 2021, ch. 56, § 1.

24-17-5. Contract information.

A. A provider is responsible for ensuring that a continuing care contract is written in clear and understandable language.

B. A continuing care contract shall, at a minimum:

(1) describe the community's admission policies, including age, health status and minimum financial requirements, if any;

(2) describe the health and financial conditions required for a person to continue to be a resident;

(3) describe the circumstances under which the resident will be permitted to remain in the community in the event of financial difficulties of the resident;

(4) list the total consideration paid, including donations, entrance fees, subscription fees, periodic fees and other fees paid or payable; provided, however, that a provider cannot require a resident to transfer all the resident's assets or the resident's real property to the provider or community as a condition for providing continuing care and the provider shall reserve the right to charge periodic fees;

(5) describe in detail all items of service to be received by the resident, such as food, shelter, medical care, nursing care and other health services, and whether services will be provided for a designated time period or for the resident's lifetime;

(6) as an addendum to the contract, provide a description of items of service, if any, that are available to the resident but that are not covered in the entrance or monthly fee;

(7) specify taxes and utilities, if any, that the resident must pay;

(8) specify that deposits or entrance fees paid by or for a resident shall be held in trust for the benefit of the resident in a federally insured New Mexico bank until the resident has taken possession of the resident's unit or the resident's contract cancellation period has ended, whichever occurs later;

(9) state the terms under which a continuing care contract may be canceled by the resident or the community and the basis for establishing the amount of refund of the entrance fee;

(10) state the terms under which a continuing care contract is canceled by the death of the resident and the basis for establishing the amount of refund, if any, of the entrance fee;

(11) state when fees will be subject to periodic increases and what the policy for increases will be; provided, however, that the provider shall give advance notice of not less than thirty days to the residents before the change becomes effective and increases shall be based upon economic necessity, the reasonable cost of operating the community, the cost of care and a reasonable return on investment as defined by rules promulgated by the aging and long-term services department;

(12) state the entrance fee and periodic fees that will be charged if the resident marries while living in the community, the terms concerning the entry of a spouse to the community and the consequences if the spouse does not meet the requirements for entry;

(13) indicate funeral and burial services that are not furnished by the provider;

(14) state the rules and regulations of the provider then in effect and state the circumstances under which the provider claims to be entitled to have access to the resident's unit;

(15) list the resident's and provider's respective rights and obligations as to any real or personal property of the resident transferred to or placed in the custody of the provider;

(16) describe the rights of the residents to form a residents' association and the participation, if any, of the association in the community's decision-making process;

(17) describe the living quarters purchased by or assigned to the resident;

(18) provide under what conditions, if any, the resident may assign the use of a unit to another;

(19) include the policy and procedure with regard to changes in accommodations due to an increase or decrease in the number of persons occupying an individual unit;

(20) state the conditions upon which the community may sublet or relet a resident's unit;

(21) state the fee adjustments that will be made in the event of a resident's voluntary absence from the community for an extended period of time;

(22) include the procedures to be followed when the provider temporarily or permanently changes the resident's accommodations, either within the community or by transfer to a health facility; provided that the contract shall state that such changes in accommodations shall only be made to protect the health or safety of the resident or the general and economic welfare of all other residents of the community;

(23) if the community includes a nursing facility, describe the admissions policies and what will occur if a nursing facility bed is not available at the time it is needed;

(24) in the event the resident is offered a priority for nursing facility admission at a facility that is not owned by the community, describe with which nursing facility the formal arrangement is made and what will occur if a nursing facility bed is not available at the time it is needed;

(25) include the policy and procedures for determining under what circumstances a resident will be considered incapable of independent living and will require a permanent move to a nursing facility. The contract shall also state who will participate in the decision for permanent residency in the nursing facility and shall provide that the resident shall have an advocate involved in that decision; provided that if the resident has no family member, attorney, guardian or other responsible person to act as the resident's advocate, the provider shall request the local office of the human services department [health care authority department] to serve as advocate;

(26) specify the types of insurance, if any, the resident is required to maintain, including medicare, other health insurance and property insurance;

(27) specify the circumstances, if any, under which the resident will be required to apply for any public assistance, including medical assistance, or any other public benefit programs;

(28) in bold type of not less than twelve-point type on the signature page, state that a contract for continuing care may present a significant financial risk and that a person considering a continuing care contract should consult with an attorney and with a financial advisor concerning the advisability of pursuing continuing care; provided, however, that failure to consult with an attorney or financial advisor shall not be raised as a defense to bar recovery for a resident in any claims arising under the provisions of the Continuing Care Act;

(29) in bold type of not less than twelve-point type on the front of the contract, state that nothing in the contract or the Continuing Care Act should be construed to constitute approval, recommendation or endorsement of any continuing care community by the state of New Mexico;

(30) contain a provision describing the community's plan for resident relocation upon closure or circumstances that necessitate relocation;

(31) in immediate proximity to the space reserved in the contract for the signature of the resident, in bold type of not less than twelve-point type, state the following:

"You, the buyer, may cancel this transaction at any time prior to midnight of the seventh day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right."; and

(32) contain a completed form, in duplicate, captioned "Notice of Cancellation", which shall be attached to the contract and easily detachable, and which shall contain in twelve-point boldface type the following information and statements in the same language as that used in the contract.

"NOTICE OF CANCELLATION

Date: _____
(enter date of transaction)

You may cancel this transaction without any penalty or obligation within seven days from the above date. If you cancel, any payments made by you under the contract or sale and any negotiable instrument executed by you will be returned within ten business days following receipt by the provider of your cancellation notice, and any security interest or lien arising out of the transaction will be canceled.

To cancel this transaction, deliver a signed and dated copy of this cancellation notice or any other written notice, or send a telegram, to:

_____
(Name of Provider)

at _____

(Address of Provider's Place of Business)

not later than midnight of _____

(Date)

I hereby cancel this transaction.

_____
(Buyer's Signature)

_____
(Date)".

History: Laws 1985, ch. 102, § 5; 2005, ch. 215, § 3; 2010, ch. 88, § 5; 2021, ch. 56, § 2.

24-17-6. Requirements for financial reserves.

A. Any deposits or entrance fees paid by or for a resident shall be held in trust for the benefit of the resident in a federally insured New Mexico bank until the resident has occupied the resident's unit or the resident's contract cancellation period has ended, whichever occurs later.

B. In addition to the amounts held in trust for specific residents under Subsection A of this section, a community that provides a type A agreement shall maintain at all times liquid reserves equal to the principal and interest payments due for a twelve-month period on all accounts of any mortgage loan and other long-term debt, as well as three months' worth of net operating expenses.

C. A community that provides a type A or type B agreement shall keep the funds maintained under Subsection A of this section in federally insured bank accounts that are separate from the community's operating accounts.

D. For communities that provide type B agreements, reserves shall be calculated on a prorated basis for residents who fall under type B agreements.

History: Laws 1985, ch. 102, § 6; 2005, ch. 215, § 4; 2010, ch. 88, § 6.

24-17-7. Disclosure statements filed with the aging and long-term services department for public inspection.

No later than July 1, 2022 and each year thereafter, within one hundred eighty days after the end of a community's fiscal year, a provider shall provide a copy of the disclosure statement and any amendments to that statement to the aging and long-term services department for public inspection during regular working hours.

History: Laws 1985, ch. 102, § 7; 2021, ch. 56, § 3.

24-17-8. Consumer's guide to continuing care communities.

The office of the attorney general and the aging and long-term services department may publish and distribute a consumer's guide to continuing care communities and may publish an annual directory of communities in New Mexico.

History: Laws 1985, ch. 102, § 8; 2005, ch. 215, § 5.

24-17-9. Repealed.

24-17-10. Restraint of prohibited acts; remedies.

A. Whenever the attorney general has reasonable belief that any person is violating or is about to violate any provision of the Continuing Care Act, or any regulation promulgated pursuant to that act, and that proceedings would be in the public interest, the attorney general may bring an action in the name of the state to restrain or prevent violations of that act or regulations promulgated pursuant to that act. The action may be brought in the district court of the county in which the person resides or has the person's principal place of business or in the district court for Santa Fe county. The attorney general acting on behalf of the state shall not be required to post bond when seeking a temporary or permanent injunction in such action.

B. In any action filed pursuant to this section of the Continuing Care Act, including an action with respect to unimproved real property, the attorney general may petition the district court for temporary or permanent injunctive relief, and restitution or remedies available pursuant to Section 24-17-15 NMSA 1978.

C. Any person who is the subject of an action brought under this section shall have the right to demand a jury trial.

History: Laws 1985, ch. 102, § 10; 1991, ch. 263, § 10; 2010, ch. 88, § 7.

24-17-11. Applicability.

A. The provisions of the Continuing Care Act apply equally to for-profit and nonprofit provider organizations and shall be construed as the minimum requirements to be imposed upon any person offering or providing continuing care.

B. The provisions of the Continuing Care Act do not apply to closed-membership organizations that operate communities solely for the benefit of their members.

History: Laws 1985, ch. 102, § 11.

24-17-12. Right to a written transfer policy.

A provider shall adopt and follow a written policy establishing the procedure and criteria applicable when deciding to transfer residents from one level of care to another.

History: Laws 1991, ch. 263, § 1.

24-17-13. Right to organize and participate.

A. Residents have the right to organize a resident association and to engage in concerted activities for the purpose of keeping themselves informed of the operation of the facility or for the purpose of other mutual aid or protection. A provider shall take appropriate steps to encourage and facilitate the establishment of a resident association in each facility. At a minimum, these steps shall include the posting in conspicuous places of written notices of the right of residents to organize into a resident association and to use the facility for association meetings.

B. The administration of an operating facility shall meet at least quarterly with the resident association, if one exists, or with interested residents if there is no resident association. The following procedures shall apply:

(1) the provider shall notify all residents at least seven days in advance of each meeting;

(2) the provider shall post the meeting agenda in a conspicuous place and make copies of it available; and

(3) if the resident association requests, the provider shall ensure that a member or an authorized representative of the board of directors, a general partner or a principal owner attends the meeting.

History: Laws 1991, ch. 263, § 2.

24-17-14. Right to protection against retaliatory conduct.

Retaliatory conduct by a provider or any person acting on the provider's behalf against a resident for lawful efforts to secure or enforce his legal rights as a resident is a violation of the Continuing Care Act.

History: Laws 1991, ch. 263, § 3.

24-17-15. Right to civil action for damages.

A. Residents, as a class or otherwise, may bring an action in a court of competent jurisdiction to recover actual and punitive damages for injury resulting from a violation of the Continuing Care Act.

B. The court may award reasonable attorneys' fees and costs to the prevailing party in an action brought under this section.

C. The right of a resident to bring an action pursuant to this section is in addition to any other rights or remedies the resident may have by statute or common law.

History: Laws 1991, ch. 263, § 4.

24-17-16. Identification and procedures for correction of violations.

A. The aging and long-term services department shall review disclosure statements filed pursuant to the Continuing Care Act for compliance with that act.

B. If the aging and long-term services department determines that a person or an organization has engaged in or is about to engage in an act or practice constituting a violation of the Continuing Care Act or any rule adopted pursuant to that act, the aging and long-term services department shall issue a notice of violation in writing to that person or organization and send copies to the resident association of any facility affected by the notice.

C. The notice of violation shall state the following:

(1) a description of a violation at issue;

(2) the action that, in the judgment of the aging and long-term services department, the provider should take to conform to the law or the assurances that the aging and long-term services department requires to establish that no violation is about to occur;

(3) the compliance date by which the provider shall correct any violation or submit assurances;

(4) the requirements for filing a report of compliance; and

(5) the applicable sanctions for failure to correct the violation or failure to file the report of compliance according to the terms of the notice of violation.

D. At any time after receipt of a notice of violation, the person or organization to which the notice is addressed or the aging and long-term services department may request a conference. The aging and long-term services department shall schedule a conference within thirty days of a request.

E. The purpose of the conference is to discuss the contents of the notice of violation and to assist the addressee to comply with the requirements of the Continuing Care Act. Subject to rules that the aging and long-term services department may promulgate, a

representative of the resident association at any facility affected by the notice shall have a right to attend the conference.

F. A person receiving a notice of violation shall submit a signed report of compliance as provided by the notice. The aging and long-term services department shall send a copy to the resident association of any facility affected by the notice.

G. Upon receipt of the report of compliance, the aging and long-term services department shall take steps to determine that compliance has been achieved.

History: Laws 1991, ch. 263, § 5; 2021, ch. 56, § 4.

24-17-17. Rules and regulations authorized.

The aging and long-term services department shall promulgate all rules and regulations necessary or appropriate to administer the provisions of the Continuing Care Act.

History: Laws 1991, ch. 263, § 6; 2010, ch. 88, § 8; 2021, ch. 56, § 5.

24-17-18. Report to attorney general; civil action; civil penalties.

A. A person may report an alleged violation of the Continuing Care Act or rules promulgated pursuant to that act to the attorney general or to the aging and long-term services department.

B. Any time after the aging and long-term services department issues a notice of violation, the department may send the attorney general a written report alleging a possible violation of the Continuing Care Act or any rule adopted pursuant to that act.

C. Upon receipt of a report from any source alleging a violation of the Continuing Care Act or rules promulgated pursuant to that act, the attorney general shall promptly review the allegation. Upon finding that an allegation received pursuant to this subsection is credible, the attorney general shall file an appropriate action against the alleged violator in a court of competent jurisdiction.

D. Upon finding violations of any provisions of the Continuing Care Act or any rule adopted pursuant to that act, the court may impose a civil penalty in the amount of five dollars ($5.00) per resident or up to five hundred dollars ($500), in the discretion of the court, for each day that the violation remains uncorrected after the compliance date stipulated in a notice of violation issued pursuant to the Continuing Care Act.

History: Laws 1991, ch. 263, § 7; 2021, ch. 56, § 6.

ARTICLE 17A
Long-Term Care Services

24-17A-1. Recompiled.

History: Laws 1998, ch. 82, § 1; § 24-17A-1, recompiled and amended as § 24A-5-1 by Laws 2024, ch. 39, § 46.

Recompilations. — Laws 2024, ch. 39, § 46 recompiled and amended former 24-17A-1 NMSA 1978 as 24A-5-1 NMSA 1978, effective July 1, 2024.

24-17A-2. Recompiled.

History: Laws 1998, ch. 82, § 2; § 24-17A-2, recompiled as § 24A-5-2 by Laws 2024, ch. 39, § 132.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-17A-2 NMSA 1978 as 24A-5-2 NMSA 1978, effective July 1, 2024.

24-17A-3. Recompiled.

History: Laws 1998, ch. 82, § 3; § 24-17A-3, recompiled and amended as § 24A-5-3 by Laws 2024, ch. 39, § 47.

24-17A-4. Recompiled.

History: Laws 1998, ch. 82, § 4; § 24-17A-4, recompiled as § 24A-5-4 by Laws 2024, ch. 39, § 132.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-17A-4 NMSA 1978 as 24A-5-4 NMSA 1978, effective July 1, 2024.

24-17A-5. Recompiled.

History: Laws 1998, ch. 82, § 5; § 24-17A-5, recompiled as § 24A-5-5 by Laws 2024, ch. 39, § 132.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-17A-5 NMSA 1978 as 24A-5-5 NMSA 1978, effective July 1, 2024.

24-17A-6. Senior center food gardens authorized.

A. The aging and long-term services department shall permit any senior center to coordinate the planting, cultivation, growing, tending and harvesting by senior center

staff and senior participants of edible fruits and vegetables on the senior center's premises for inclusion in food service or distribution to senior participants.

B. For the purposes of this section:

(1) "senior center" means a community-based center:

(a) that serves as a resource for information on aging, support for family caregivers and training; and

(b) where senior participants receive services and participate in programs; and

(2) "senior participant" means an individual who is at least fifty years of age or older or who is otherwise eligible to receive services or to participate in programs administered by the aging and long-term services department or its designees.

History: Laws 2019, ch. 152, § 1.

ARTICLE 17B
Long-Term Care Facility Dementia Training (Recompiled.)

24-17B-1. Recompiled.

History: Laws 2021, ch. 111, § 1; § 24-17B-1, recompiled and amended as § 24A-6-1 by Laws 2024, ch. 39, § 48.

24-17B-2. Recompiled.

History: Laws 2021, ch. 111, § 2; 2023, ch. 163, § 1; § 24-17B-2, recompiled and amended as § 24A-6-2 by Laws 2024, ch. 39, § 49.

24-17B-3. Recompiled.

History: Laws 2021, ch. 111, § 3; 2023, ch. 163, § 2; § 24-17B-3, recompiled and amended as § 24A-6-3 by Laws 2024, ch. 39, § 50.

24-17B-4. Recompiled.

History: Laws 2021, ch. 111, § 4; 2023, ch. 163, § 3; § 24-17B-4, recompiled and amended as § 24A-6-4 by Laws 2024, ch. 39, § 51.

24-17B-5. Recompiled.

History: Laws 2021, ch. 111, § 5; 2023, ch. 163, § 4; § 24-17B-5, recompiled and amended as § 24A-6-5 by Laws 2024, ch. 39, § 52.

ARTICLE 18
Children's and Juvenile Facility Criminal Records Screening (Recompiled.)

24-18-1 to 24-18-4. Recompiled.

ARTICLE 19
Children's Trust Fund

24-19-1. Short title.

Chapter 24, Article 19 NMSA 1978 may be cited as the "Children's Trust Fund Act".

History: Laws 1986, ch. 15, § 1; 2005, ch. 65, § 1.

24-19-2. Purpose.

It is the purpose of the Children's Trust Fund Act to:

A. be a statewide resource that advocates for and educates about the prevention of child abuse and neglect;

B. provide the means to develop innovative children's projects and programs that address one or more of the following:

(1) preventing abuse and neglect of children;

(2) providing medical, psychological and other appropriate treatment for children who are victims of abuse or neglect; and

(3) developing community-based services aimed at the prevention and treatment of child abuse and neglect; and

C. manage the next generation fund projects and programs.

History: Laws 1986, ch. 15, § 2; 2005, ch. 65, § 2; 2013, ch. 25, § 1.

24-19-3. Definitions.

As used in the Children's Trust Fund Act:

A. "board" means the children's trust fund board of trustees;

B. "children's projects and programs" means projects and programs that provide services to children, including services to their families, consistent with the purposes of the Children's Trust Fund Act;

C. "council" means the next generation council;

D. "department" means the children, youth and families department;

E. "next generation fund projects and programs" means projects and programs funded from the next generation fund that meet the requirements for funding provided in Section 24-19-10 NMSA 1978; and

F. "secretary" means the secretary of children, youth and families.

History: Laws 1986, ch. 15, § 3; 1992, ch. 57, § 19; 2005, ch. 65, § 3; 2013, ch. 25, § 2.

24-19-4. Children's trust fund created; expenditure limitations.

A. The "children's trust fund" is created in the state treasury. The children's trust fund may be used for any purpose enumerated in Section 24-19-2 NMSA 1978. All income received from investment of the fund shall be credited to the fund. No money appropriated to the fund or otherwise accruing to it shall be disbursed in any manner except as provided in the Children's Trust Fund Act.

B. The children's trust fund shall be administered by the department for the purpose of funding children's projects and programs from the income received from investment of the fund; provided that none of the income shall be used for capital expenditures. All income from investment of the fund is appropriated to the department for that purpose or for administrative costs as provided in Subsection C of this section. Grants, distributions and transfers of money from the fund shall be made only from the income received from investment of the fund and from other sources pursuant to Section 24-19-9 NMSA 1978, including federal funds, private donations, bequests and other public and private grants.

C. Up to ten percent of the income received from investment of the children's trust fund may be expended for costs of administration of the fund and administration of the children's projects and programs undertaken with fund money. Administrative costs include per diem and mileage, staff salaries and expenses related to administration of the fund.

D. Disbursements from income credited to the children's trust fund and appropriated to the department shall be made only upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of children, youth and

families or the secretary's designated representative to fund children's projects and programs approved by the board.

E. One-half of the money transferred to the children's trust fund pursuant to Section 40-1-11 NMSA 1978 and all of the money transferred to the children's trust fund pursuant to Section 66-3-420 NMSA 1978 shall be deemed income received from investment of the fund.

History: Laws 1986, ch. 15, § 4; 1990, ch. 26, § 1; 1992, ch. 57, § 20; 1993, ch. 175, § 1; 1993, ch. 199, § 1; 2004, ch. 74, § 1; 2005, ch. 65, § 4; 2013, ch. 25, § 3.

24-19-5. Children's trust fund board of trustees created; members.

A. There is created the "children's trust fund board of trustees" consisting of thirteen nonpartisan members, not employees of the state, knowledgeable in the area of children's programs and representative of multiple, diverse perspectives within the state, who shall be appointed by the governor with the advice and consent of the senate. Of these members, at least two shall be individuals of recognized standing in the field of children's services. On the initial board, two members shall be appointed for terms ending on July 1, 1988; two members shall be appointed for terms ending on July 1, 1989; and three members shall be appointed for terms ending on July 1, 1990. Thereafter, appointments shall be made for terms of four years. Vacancies of appointed members shall be filled by appointment by the governor for the unexpired term.

B. The board shall select a person from its membership to serve as chair.

History: Laws 1986, ch. 15, § 5; 1987, ch. 135, § 1; 2013, ch. 25, § 4.

24-19-6. Per diem and mileage; board.

Members of the board shall be reimbursed as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

History: Laws 1986, ch. 15, § 6.

24-19-7. Duties of the board.

At least four times a year, the board shall meet upon the call of its chair to take all action necessary or proper for the administration of the Children's Trust Fund Act. The board shall also approve or disapprove proposals submitted and shall base its decision on the proposals' merit and feasibility, the best interest of the beneficiaries of the children's project or program proposals and the capacity of the children's projects' or programs' success or failure for evaluation.

History: Laws 1986, ch. 15, § 7; 2005, ch. 65, § 6; 2013, ch. 25, § 5.

24-19-8. Children, youth and families department; additional powers and duties.

The department shall:

A. promulgate rules approved by the board;

B. transmit proposals for children's projects and programs to the board and next generation fund projects and programs to the council for evaluation and report on the proposals;

C. enter into contracts approved by the board to carry out the proposed children's project or program or next generation fund project or program, provided that:

(1) not more than fifty percent of the total funds distributed for any one fiscal year from the children's trust fund shall be allocated for any single children's project or program;

(2) not more than fifty percent of the total funds distributed for any one fiscal year from the next generation fund shall be allocated for any single next generation fund project or program;

(3) each children's project or program shall be funded for a specified period, not to exceed four years, and funds shall not be used for maintenance of ongoing or permanent efforts extending beyond the period specified, except that a children's project or program may be extended once for a period not to exceed the original, and the board shall approve rules providing procedures and guidelines for the preparation and approval of proposals for children's projects and programs and providing for any other matter the board deems necessary for the administration of the Children's Trust Fund Act; and

(4) no contract shall be entered into if the department finds it contrary to law;

D. furnish the board and the council with the necessary technical and clerical assistance;

E. adopt standard contract provisions; and

F. report at least annually to the governor and the legislature on the progress of its work and the results of children's projects and programs and next generation fund projects and programs.

History: Laws 1986, ch. 15, § 8; 2005, ch. 65, § 8; 2013, ch. 25, § 6.

24-19-9. Acceptance of federal funds and private donations.

To carry out the provisions of the Children's Trust Fund Act, the department and the children's trust fund may accept any federal matching funds or grants for children's projects and programs or next generation fund projects and programs. The department may accept donations and bequests from private sources for deposit in the children's trust fund or the next generation fund, as applicable. The board shall distribute these funds as specified by the granting entity or donor.

History: Laws 1986, ch. 15, § 9; 2005, ch. 65, § 9; 2013, ch. 25, § 7.

24-19-10. Next generation fund; created; expenditure limitations.

A. The "next generation fund" is created in the state treasury. The next generation fund may be used for any purpose enumerated in Section 24-19-2 NMSA 1978. All income received from investment of the fund shall be credited to the fund. No money appropriated to the fund or otherwise accruing to it shall be disbursed in any manner except as provided in the Children's Trust Fund Act.

B. The fund shall be used to fund next generation fund projects and programs that are approved by the board. Next generation fund projects and programs shall:

(1) provide positive child and youth development activities that support physical, mental and social well-being;

(2) promote strong, healthy families and help to prevent child abuse and neglect;

(3) promote community service, leadership and citizenship; and

(4) provide community coordination of child and youth development programming across the age zero to twenty-four developmental continuum.

C. The next generation fund shall be administered by the department, and the income from investment of the fund is appropriated to the department to carry out the purposes of the fund. None of the income shall be used for capital expenditures. Grants, distributions and transfers of money from the fund shall be made only from the income received from investment of the fund.

D. Up to ten percent of the income received from investment of the fund may be expended for costs of administering the fund and next generation projects and programs. Administrative costs include per diem and mileage, staff salaries and expenses related to administration of the fund.

E. Disbursements from the fund shall be made by warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of children, youth and families or the secretary's designated representative.

History: Laws 2005, ch. 65, § 5; 2013, ch. 25, § 8.

24-19-11. Next generation council; created; membership; purpose.

A. The "next generation council" is created. The board shall appoint ten members, at least two from each federal congressional district, who are not employees of the state and who are knowledgeable in the area of positive child and youth development programs. Members serve at the pleasure of the board. Members shall select a member to serve as chair of the council. Members are entitled to per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

B. The council shall evaluate proposed next generation fund projects and programs and make funding recommendations to the board. The board shall approve or disapprove next generation fund projects and programs for funding and transmit those proposals to the department.

History: Laws 2005, ch. 65, § 7; 2013, ch. 25, § 9.

ARTICLE 20
Health Research

24-20-1. Medical trust fund for cancer and other medical research; appropriation.

A. There is created at the university of New Mexico school of medicine a medical trust fund to be administered by the school of medicine. The fund shall consist of balances transferred to the fund from the dedicated health research fund and any other distributions, transfers and deposits that may be made to the fund. Earnings from investment of the medical trust fund are appropriated to the university of New Mexico school of medicine for cancer and other medical research.

B. The university of New Mexico school of medicine shall report annually to the commission on higher education, the department of health and the legislative finance committee regarding the use of the earnings on the medical trust fund.

History: 1978 Comp., § 24-20-1, enacted by Laws 1993, ch. 358, § 3.

24-20-2. Repealed.

History: Laws 1990, ch. 103, § 1; 1993, ch. 215, § 1; repealed by Laws 1995, ch. 189, § 2.

24-20-3. Brain injury advisory council; created; powers and duties.

A. The "brain injury advisory council" is created to advise the governor's commission on disability, the governor, the legislature and other state agencies.

B. The brain injury advisory council shall consist of no fewer than eighteen and no more than twenty-four members appointed by the governor and shall include survivors of brain injuries; family members of persons with brain injuries; and health care professionals and other representatives of private sector organizations and state agencies that provide services and support to persons with brain injuries.

C. Members shall be appointed for staggered terms of three years, so that the terms of one-third of the members shall expire in a given year.

D. Members shall elect annually a chair and vice chair. Staff and other administrative support shall be provided by the governor's commission on disability or other state agency as assigned by the governor. Members shall meet at the call of the chair.

E. Members who are not state employees may receive per diem and travel expenses as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] for state employees. Reasonable accommodations shall be made available to permit full participation in council activities by its members, including personal assistance to members who are survivors of brain injuries and respite care for members who are family members of persons with brain injuries.

F. The brain injury advisory council shall:

(1) study and make recommendations to the governor's commission on disability, the governor, the legislature and other state agencies concerning case management, community support systems, long-term care, employment, emergency medical services, rehabilitation and prevention and the improvement and coordination of state activities relative to the concerns of persons with brain injuries and their families or other caregivers; and

(2) advise appropriate state agencies and private organizations on the development of services and supports that meet the needs of persons with brain injuries.

History: Laws 1995, ch. 189, § 1; 2013, ch. 127, § 1.

24-20-4. Amyotrophic lateral sclerosis research fund.

The "amyotrophic lateral sclerosis research fund" is created in the state treasury. The fund shall consist of distributions made to the fund pursuant to the Tax Administration Act [Chapter 7, Article 1 NMSA 1978]. Money in the fund is appropriated to the board of regents of the university of New Mexico for amyotrophic lateral sclerosis research. Disbursements from the fund shall be by warrant of the secretary of finance

and administration upon vouchers signed by the president of the university of New Mexico. Money in the fund shall revert to the general fund at the end of a fiscal year.

History: Laws 2005, ch. 56, § 3.

ARTICLE 21
Genetic Information Privacy

24-21-1. Short title.

Chapter 24, Article 21 NMSA 1978 may be cited as the "Genetic Information Privacy Act".

History: Laws 1998, ch. 77, § 1; 2015, ch. 156, § 1.

24-21-2. Definitions.

As used in the Genetic Information Privacy Act:

A. "DNA" means deoxyribonucleic acid, including mitochondrial DNA, complementary DNA and DNA derived from ribonucleic acid;

B. "gene products" means gene fragments, ribonucleic acids or proteins derived from DNA that would be a reflection of or indicate DNA sequence information;

C. "genetic analysis" means a test of an individual's DNA, gene products or chromosomes that indicates a propensity for or susceptibility to illness, disease, impairment or other disorders, whether physical or mental; that demonstrates genetic or chromosomal damage due to environmental factors; or that indicates carrier status for disease or disorder; excluded, however, are routine physical measurements, chemical, blood and urine analysis, tests for drugs, tests for the presence of HIV virus and any other tests or analyses commonly accepted in clinical practice at the time ordered;

D. "genetic information" means information about the genetic makeup of an individual or members of an individual's family, including information resulting from genetic testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services;

E. "genetic propensity" means the presence in an individual or members of an individual's family of real or perceived variations in DNA or other genetic material from that of the normal genome that do not represent the outward physical or medical signs of a genetic disease at the time of consideration;

F. "genetic testing" means a test of an individual's DNA, ribonucleic acid, chromosomes or proteins, including carrier status, that are linked with physical or

mental disorders, impairments or genetic characteristics or that indicate that an individual may be predisposed to an illness, disease, impairment or other disorder;

G. "insurer" means an insurance company, insurance service or insurance organization that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Paragraph (2) of Subsection (b) of Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended. "Insurer" does not include an insurance company that is licensed under the Prepaid Dental Plan Law [Chapter 59A, Article 48 NMSA 1978] or a company that is solely engaged in the sale of dental insurance and is not licensed under the Prepaid Dental Plan Law, but under another provision of the New Mexico Insurance Code [Chapter 59A NMSA 1978 except Articles 30A and 42A]; and

H. "laboratory" means a facility accredited pursuant to the federal clinical laboratory improvement amendments for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings and includes procedures to determine, measure or otherwise describe the presence or absence of various substances or organisms in the body.

History: Laws 1998, ch. 77, § 2; 2005, ch. 204, § 1; 2015, ch. 156, § 2.

24-21-3. Genetic analysis prohibited without informed consent; exceptions.

A. Except as provided in Subsection C of this section, no person shall obtain genetic information or samples for genetic analysis from an individual without first obtaining informed and written consent from the individual or the individual's authorized representative.

B. Except as provided in Subsection C of this section, genetic analysis of an individual or collection, retention, transmission or use of genetic information without the informed and written consent of the individual or the individual's authorized representative is prohibited.

C. An individual's DNA, genetic information or the results of genetic analysis may be obtained, retained, transmitted or used without the individual's written and informed consent pursuant to federal or state law or regulations only:

(1) to identify an individual in the course of a criminal investigation by a law enforcement agency;

(2) if the individual has been convicted of a felony, for purposes of maintaining a DNA database for law enforcement purposes;

(3) to identify a deceased individual;

(4) to establish parental identity;

(5) to screen newborns;

(6) if the DNA, genetic information or results of genetic analysis are not identified with the individual or the individual's family members;

(7) by a court for determination of damage awards pursuant to the Genetic Information Privacy Act;

(8) by medical repositories or registries;

(9) for the purpose of medical or scientific research and education, including retention of gene products, genetic information or genetic analysis if the identity of the individual or the individual's family members is not disclosed;

(10) for the purpose of emergency medical treatment consistent with applicable law; or

(11) by a laboratory conducting an analysis or test of a specified individual pursuant to a written order to the laboratory from a health care practitioner or the health care practitioner's agent, including by electronic transmission.

D. Actions of an insurer and third parties dealing with an insurer in the ordinary course of conducting and administering the business of life, disability income or long-term care insurance are exempt from the provisions of this section if the use of genetic analysis or genetic information for underwriting purposes is based on sound actuarial principles or related to actual or reasonably anticipated experience. However, before or at the time of collecting genetic information for use in conducting and administering the business of life, disability income or long-term care insurance, the insurer shall notify in writing an applicant for insurance or the insured that the information may be used, transmitted or retained solely for the purpose of conducting and administering the business of life, disability income or long-term care insurance.

E. Nothing in Paragraph (5), (8), (9), (10) or (11) of Subsection C of this section authorizes a person to obtain, retain, transmit or use an individual's DNA, genetic information or the results of genetic analysis if the individual or the individual's authorized representative or guardian, or the parent or guardian of a minor child, gives notice to the person of an objection on the basis of religious tenets or practices.

History: Laws 1998, ch. 77, § 3; 2015, ch. 156, § 3.

24-21-4. Genetic discrimination prohibited.

A. Discrimination by an insurer against an individual or member of the individual's family on the basis of genetic analysis, genetic information or genetic propensity is prohibited.

B. The provisions of this section do not require a health insurer to provide particular benefits other than those provided under the terms of the plan or coverage. A health insurer shall not consider a genetic propensity, susceptibility or carrier status as a pre-existing condition for the purpose of limiting or excluding benefits, establishing rates or providing coverage.

C. The provisions of this section do not prohibit use of genetic analysis, genetic propensity or genetic information by an insurer in the ordinary conduct of business in connection with life, disability income or long-term care insurance if use of genetic analysis, genetic propensity or genetic information in underwriting is based on sound actuarial principles or related to actual or reasonably anticipated experience.

D. It is unlawful for a person to use genetic information in employment, recruiting, housing or lending decisions or in extending public accommodations and services.

History: Laws 1998, ch. 77, § 4; 2005, ch. 204, § 2; 2015, ch. 156, § 4.

24-21-5. Rights of retention.

A. Unless otherwise authorized by Subsection C of Section 24-21-3 NMSA 1978, no person shall retain an individual's genetic information, gene products or samples for genetic analysis without first obtaining informed and written consent from the individual or the individual's authorized representative. This subsection does not affect the status of original medical records of patients, and the rules of confidentiality and accessibility applicable to the records continue in force.

B. An individual's genetic information or samples for genetic analysis shall be destroyed promptly upon the specific request by that individual or that individual's authorized representative unless:

(1) retention is necessary for the purposes of a criminal or death investigation or a criminal or juvenile proceeding;

(2) retention is authorized by order of a court of competent jurisdiction;

(3) retention is authorized under a research protocol approved by an institution review board pursuant to federal law or a medical registry or repository authorized by state or federal law; or

(4) the genetic information or samples for genetic analysis have been obtained pursuant to Subsection C of Section 24-21-3 NMSA 1978.

C. Actions of an insurer and third parties dealing with an insurer in the ordinary course of conducting and administering the business of life, disability income or long-term care insurance are exempt from the provisions of this section. However, before or at the time of collecting genetic information for use in conducting and administering the business of life, disability income or long-term care insurance, the insurer shall notify in writing an applicant for insurance or the insured that the information may be used, transmitted or retained solely for the purpose of conducting and administering the business of life, disability income or long-term care insurance.

D. Nothing in Paragraph (3) or (4) of Subsection B of this section authorizes retention of an individual's genetic information or samples for genetic analysis if the individual or the individual's authorized representative or guardian, or the parent or guardian of a minor child, objects on the basis of religious tenets or practices.

History: Laws 1998, ch. 77, § 5; 2015, ch. 156, § 5.

24-21-6. Penalties.

A. The attorney general or a district attorney may bring a civil action against a person for violating the provisions of the Genetic Information Privacy Act or to otherwise enforce those provisions.

B. An individual whose rights under the provisions of the Genetic Information Privacy Act have been violated may bring a civil action for damages or other relief.

C. The court may order a person who violates the provisions of the Genetic Information Privacy Act to comply with those provisions and may order other appropriate relief, including:

(1) directing an insurer who has violated Section 24-21-3 or 24-21-4 NMSA 1978 to provide a policy for hospital and medical expenses, including health insurance, group disability insurance or long-term care coverage, to the injured individual under the same terms and conditions as would have applied had the violation not occurred;

(2) actual damages;

(3) damages of up to five thousand dollars ($5,000) in addition to any economic loss if the violation results from willful or grossly negligent conduct; and

(4) reasonable attorney fees and appropriate court costs.

D. Pursuant to Subsection C of Section 24-21-3 NMSA 1978, the court may use genetic information to determine the cause of damage or injury and penalty awards.

E. Each instance of wrongful collection, analysis, retention, disclosure or use of genetic information constitutes a separate and actionable violation of the Genetic Information Privacy Act.

History: Laws 1998, ch. 77, § 6; 2015, ch. 156, § 6.

24-21-7. Application of act.

The provisions of the Genetic Information Privacy Act shall apply to genetic analysis performed and genetic information and gene products obtained after May 20, 1998, except that Section 24-21-4 NMSA 1978 and proceedings brought alleging violations of that section shall apply to genetic analysis whenever performed and genetic information and gene products whenever obtained.

History: Laws 1998, ch. 77, § 7; 1999, ch. 82, § 1.

ARTICLE 22
Safe Haven for Infants

24-22-1. Short title.

Chapter 24, Article 22 NMSA 1978 may be cited as the "Safe Haven for Infants Act".

History: Laws 2001, ch. 31, § 1; 2001, ch. 132, § 1; 2005, ch. 26, § 1.

24-22-1.1. Purpose.

The purpose of the Safe Haven for Infants Act is to promote the safety of infants and to immunize a parent from criminal prosecution for leaving an infant, ninety days of age or less, at a safe haven site. This act is not intended to abridge the rights or obligations created by the federal Indian Child Welfare Act of 1978 or the rights of parents.

History: Laws 2005, ch. 26, § 2; 2013, ch. 20, § 1.

24-22-2. Definitions.

As used in the Safe Haven for Infants Act:

A. "fire station" means a fire station that is certified by the state fire marshal's office;

B. "hospital" means an acute care general hospital or health care clinic licensed by the state;

C. "Indian child" means an Indian child as defined by the federal Indian Child Welfare Act of 1978;

D. "infant" means a child no more than ninety days old, as determined within a reasonable degree of medical certainty;

E. "law enforcement agency" means a law enforcement agency of the state or a political subdivision of the state;

F. "safe haven site" means a hospital, law enforcement agency or fire station that has staff on site at the time an infant is left at such a site; and

G. "staff" means an employee, contractor, agent or volunteer performing services as required and on behalf of the safe haven site.

History: Laws 2001, ch. 31, § 2; 2001, ch. 132, § 2; 2005, ch. 26, § 3; 2013, ch. 20, § 2; 2020, ch. 9, § 28.

24-22-3. Leaving an infant.

A. A person may leave an infant with the staff of a safe haven site without being subject to criminal prosecution for abandonment or abuse if the infant was born within ninety days of being left at the safe haven site, as determined within a reasonable degree of medical certainty, and if the infant is left in a condition that would not constitute abandonment or abuse of a child pursuant to Section 30-6-1 NMSA 1978.

B. A safe haven site may ask the person leaving the infant for the name of the infant's biological father or biological mother, the infant's name and the infant's medical history, but the person leaving the infant is not required to provide that information to the safe haven site.

C. The safe haven site is deemed to have received consent for medical services provided to an infant left at a safe haven site in accordance with the provisions of the Safe Haven for Infants Act or in accordance with procedures developed between the children, youth and families department and the safe haven site.

History: Laws 2001, ch. 31, § 3; 2001, ch. 132, § 3; 2005, ch. 26, § 4; 2013, ch. 20, § 3.

24-22-4. Safe haven site procedures.

A. A safe haven site shall accept an infant who is left at the safe haven site in accordance with the provisions of the Safe Haven for Infants Act.

B. In conjunction with the children, youth and families department, a safe haven site shall develop procedures for appropriate staff to accept and provide necessary medical

services to an infant left at the safe haven site and to the person leaving the infant at the safe haven site, if necessary.

C. Upon receiving an infant who is left at a safe haven site in accordance with the provisions of the Safe Haven for Infants Act, the safe haven site may provide the person leaving the infant with:

(1) information about adoption services, including the availability of private adoption services;

(2) brochures or telephone numbers for agencies that provide adoption services or counseling services; and

(3) written information regarding whom to contact at the children, youth and families department if the parent decides to seek reunification with the infant.

D. A safe haven site shall ask the person leaving the infant whether the infant has a parent who is either a member of an Indian tribe or is eligible for membership in an Indian tribe, but the person leaving the infant is not required to provide that information to the safe haven site.

E. Immediately after receiving an infant in accordance with the provisions of the Safe Haven for Infants Act, a safe haven site shall inform the children, youth and families department that the infant has been left at the safe haven site. The safe haven site shall provide the children, youth and families department with all available information regarding the child and the parents, including the identity of the child and the parents, the location of the parents and the child's medical records.

History: Laws 2001, ch. 31, § 4; 2001, ch. 132, § 4; 2005, ch. 26, § 5; 2013, ch. 20, § 4.

24-22-5. Responsibilities of the children, youth and families department.

A. The children, youth and families department shall be deemed to have emergency custody of an infant who has been left at a safe haven site according to the provisions of the Safe Haven for Infants Act.

B. Upon receiving a report of an infant left at a safe haven site pursuant to the provisions of the Safe Haven for Infants Act, the children, youth and families department shall immediately conduct an investigation, pursuant to the provisions of the Abuse and Neglect Act [Chapter 32A, Article 4 NMSA 1978].

C. When an infant is taken into custody by the children, youth and families department, the department shall make reasonable efforts to determine whether the infant is an Indian child. If the infant is an Indian child:

(1) the child's tribe shall be notified as required by Section 32A-1-14 NMSA 1978 and the federal Indian Child Welfare Act of 1978; and

(2) pre-adoptive placement and adoptive placement of the Indian child shall be in accordance with the provisions of Section 32A-5-5 NMSA 1978 regarding Indian child placement preferences.

D. The children, youth and families department shall perform public outreach functions necessary to educate the public about the Safe Haven for Infants Act, including developing literature about that act and distributing it to safe haven sites.

E. An infant left at a safe haven site in accordance with the provisions of the Safe Haven for Infants Act shall presumptively be deemed eligible and enrolled for medicaid benefits and services.

History: Laws 2001, ch. 31, § 5; 2001, ch. 132, § 5; 2005, ch. 26, § 6; 2013, ch. 20, § 5.

24-22-6. Repealed.

History: Laws 2001, ch. 31, § 6 and Laws 2001, ch. 132, § 6; repealed by Laws 2005, ch. 26, § 8.

24-22-7. Procedure if reunification is sought.

A. A person established as a parent of an infant previously left at a safe haven site shall have standing to participate in all proceedings regarding the child pursuant to the provisions of the Abuse and Neglect Act [Chapter 32A, Article 4 NMSA 1978].

B. If a person not previously established as a parent seeks reunification with an infant previously left at a safe haven site and the person's DNA indicates parentage of the infant, that person shall have standing to participate in all proceedings regarding the infant pursuant to the provisions of the Abuse and Neglect Act.

History: Laws 2001, ch. 31, § 7; 2001, ch. 132, § 7; 2005, ch. 26, § 7; 2013, ch. 20, § 6.

24-22-8. Immunity.

A safe haven site and its staff are immune from criminal liability and civil liability for accepting an infant in compliance with the provisions of the Safe Haven for Infants Act but not for subsequent negligent medical care or treatment of the infant.

History: Laws 2001, ch. 31, § 8 and Laws 2001, ch. 132, § 8; 2013, ch. 20, § 7.

ARTICLE 23
Administration of Opioid Antagonists

24-23-1. Authority to possess, store, distribute, dispense, prescribe and administer opioid antagonists; release from liability; rulemaking.

A. A person may possess an opioid antagonist, regardless of whether the person holds a prescription for the opioid antagonist.

B. Any person acting under a standing order issued by a licensed prescriber may store or distribute an opioid antagonist.

C. Pursuant to a valid prescription, a pharmacist may dispense an opioid antagonist to a person:

(1) at risk of experiencing an opioid-related drug overdose; or

(2) in a position to assist another person at risk of experiencing an opioid-related drug overdose.

D. A pharmacist may distribute an opioid antagonist to a registered overdose prevention and education program.

E. A person may administer an opioid antagonist to another person if the person:

(1) in good faith, believes the other person is experiencing a drug overdose; and

(2) acts with reasonable care in administering the drug to the other person.

F. A licensed prescriber may directly or by standing order prescribe, dispense or distribute an opioid antagonist to:

(1) a person at risk of experiencing an opioid-related drug overdose;

(2) a family member, friend or other person in a position to assist a person at risk of experiencing an opioid-related drug overdose;

(3) an employee, volunteer or representative of a community-based entity providing overdose prevention and education services that is registered with the department; or

(4) a first responder.

G. A registered overdose prevention and education program that possesses, stores, distributes or administers an opioid antagonist in accordance with department rules and on standing orders from a licensed prescriber pursuant to this section shall not be subject to civil liability, criminal prosecution or professional disciplinary action arising

from the possession, storage, distribution or administration of the opioid antagonist; provided that actions are taken with reasonable care and without willful, wanton or reckless behavior.

H. A person who possesses or who administers, dispenses or distributes an opioid antagonist to another person pursuant to this section shall not be subject to civil liability, criminal prosecution or professional disciplinary action as a result of the possession, administration, distribution or dispensing of the opioid antagonist; provided that actions are taken with reasonable care and without willful, wanton or reckless behavior.

I. The department shall create, collect and maintain any individually identifiable information pursuant to this section in a manner consistent with state and federal privacy laws.

J. The secretary shall promulgate rules relating to overdose prevention and education programs:

(1) establishing requirements and protocols for the registration of overdose prevention and education programs that are not licensed pharmacies;

(2) monitoring registered overdose prevention and education programs' storage and distribution of opioid antagonists;

(3) gathering data from overdose prevention and education programs to inform public health efforts to address overdose prevention efforts; and

(4) authorizing standards for overdose prevention education curricula, training and the certification of individuals to store and distribute opioid antagonists for the overdose prevention and education program.

K. As used in this section:

(1) "administer" means the direct application of a drug to the body of an individual by injection, inhalation, ingestion or any other means;

(2) "department" means the department of health;

(3) "dispense" means to evaluate and implement a prescription for an opioid antagonist, including the preparation and delivery of a drug or device to a patient or patient's agent;

(4) "distribute" means to deliver an opioid antagonist drug or opioid antagonist device by means other than by administering or dispensing;

(5) "first responder" means any public safety employee or volunteer whose duties include responding rapidly to an emergency, including:

(a) a law enforcement officer;

(b) a firefighter or certified volunteer firefighter; or

(c) emergency medical services personnel;

(6) "licensed prescriber" means any individual who is authorized by law to prescribe an opioid antagonist in the state;

(7) "opioid antagonist" means a drug approved by the federal food and drug administration that, when administered, negates or neutralizes in whole or in part the pharmacological effects of an opioid in the body. "Opioid antagonist" shall be limited to naloxone or other like medications that are indicated for use in reversing an opioid overdose and are approved by the department for such purpose;

(8) "possess" means to have physical control or custody of an opioid antagonist;

(9) "registered overdose prevention and education program" means any community-based organization, law enforcement agency, detention facility or school that has registered with the department in accordance with department rules and uses an approved department curriculum to teach overdose prevention and opioid antagonist administration;

(10) "standing order" means a licensed prescriber's instruction or prescribed procedure that is either patient specific or non-patient specific that can be exercised by other persons until changed or canceled by a licensed prescriber; and

(11) "storage" means possession of an opioid antagonist with the intent to dispense or distribute it.

History: Laws 2001, ch. 228, § 1; 2016, ch. 45, § 1; 2016, ch. 47, § 1.

24-23-2. Repealed.

History: Laws 2001, ch. 228, § 2; repealed by Laws 2016, ch. 45, § 4 and Laws 2016, ch. 47, § 4.

24-23-3. Opioid treatment center; opioid overdose education; naloxone.

A. As agency funding and agency supplies of naloxone permit, an opioid treatment center agency operating a federally certified program to dispense methadone or other narcotic replacement as part of a detoxification treatment or maintenance treatment shall provide each patient it treats with:

(1) opioid overdose education that:

(a) conforms to department of health or federal substance abuse and mental health services administration guidelines for opioid overdose education;

(b) explains the causes of an opioid overdose;

(c) instructs when and how to administer in accordance with medical best practices: 1) life-saving rescue techniques; and 2) an opioid antagonist; and

(d) explains how to contact appropriate emergency medical services;

(2) two doses of naloxone in either a generic form or in a form approved by the federal food and drug administration; and

(3) a prescription for naloxone.

B. As used in this section, "naloxone" means naloxone hydrochloride, which is an opioid antagonist for the treatment of opioid overdose.

History: Laws 2017, ch. 59, § 1.

ARTICLE 24
Child Care Facility Loan

24-24-1. Short title.

This act [24-24-1 to 24-24-4 NMSA 1978] may be cited as the "Child Care Facility Loan Act".

History: Laws 2003, ch. 316, § 1.

24-24-2. Purpose.

The purpose of the Child Care Facility Loan Act is to support the physical improvement, repair, safety and maintenance of licensed child care facilities throughout New Mexico by providing long-term, low-interest funding through a revolving loan fund so as to ensure availability of healthy and safe teaching environments.

History: Laws 2003, ch. 316, § 2.

24-24-3. Definitions.

As used in the Child Care Facility Loan Act:

A. "department" means the early childhood education and care department;

B. "facility" means a child care facility operated by a provider, including both family home-based and center-based programs, licensed by the department to provide care to infants, toddlers and children;

C. "fund" means the child care facility revolving loan fund;

D. "operating capital" means funds needed to meet short-term obligations, such as accounts payable, wages, debt servicing, lease and income tax payments; and

E. "provider" means a person licensed by the department to provide child care to infants, toddlers and children pursuant to Section 9-2A-8 NMSA 1978.

History: Laws 2003, ch. 316, § 3; 2023, ch. 129, § 11.

24-24-4. Fund created; administration.

A. The "child care facility revolving loan fund" is created in the New Mexico finance authority to provide low-interest, long-term loans to providers to make health and safety improvements in their facilities and for operating capital. The fund shall consist of appropriations, gifts, grants and donations to the fund, which shall be invested as provided in the New Mexico Finance Authority Act [Chapter 6, Article 21 NMSA 1978]. Money in the fund shall not revert and is appropriated to the department, which shall utilize the fund for the purposes of the Child Care Facility Loan Act. Administrative costs of the authority may be paid from the fund.

B. Money in the fund shall be used to make loans to providers that demonstrate the need to make health and safety improvements, including space expansion, in order to maintain an adequate and appropriate environment for their clients. Loans from the fund are to be made at an interest rate greater than zero percent for a term that does not exceed the useful life of the project being financed.

C. No more than twenty percent of the fund may be loaned for a single provider in a single project. The department shall give priority for loans to facilities of providers that serve proportionately high numbers of state-subsidized clients and low-income families.

D. The department, in conjunction with the New Mexico finance authority, shall adopt rules to administer and implement the Child Care Facility Loan Act. The rules shall become effective when filed in accordance with the State Rules Act [Chapter 14, Article 4 NMSA 1978].

History: Laws 2003, ch. 316, § 4; 2023, ch. 129, § 12.

ARTICLE 25
New Mexico Telehealth Act

24-25-1. Short title.

Chapter 24, Article 25 NMSA 1978 may be cited as the "New Mexico Telehealth Act".

History: Laws 2004, ch. 48, § 1; 2007, ch. 203, § 1.

24-25-2. Findings and purpose.

A. The legislature finds that:

(1) lack of primary care, specialty providers and transportation continue to be significant barriers to access to health services in medically underserved rural areas;

(2) there are parts of this state where it is difficult to attract and retain health professionals, as well as to support local health facilities in providing a continuum of health care;

(3) many health care providers in medically underserved areas are isolated from mentors and colleagues and from the information resources necessary to support them personally and professionally;

(4) using information technology to deliver medical services and information from one location to another is part of a multifaceted approach to address the problems of provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations and other forms of support;

(5) the use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice and improve access to health care in rural, medically underserved areas; and

(6) telehealth will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of general health, behavioral health and oral health care in the local area, strengthening the health infrastructure and preserving health-care-related jobs.

B. The purpose of the New Mexico Telehealth Act is to provide a framework for health care providers to follow in providing telehealth services to New Mexico citizens in a manner that provides efficient and effective access to quality health services. Telehealth services include consultations, direct patient care and education for health

care professionals, support personnel, students, families, patients and other consumers of health care services.

History: Laws 2004, ch. 48, § 2; 2007, ch. 203, § 2.

24-25-3. Definitions.

As used in the New Mexico Telehealth Act:

A. "health care provider" means a person licensed to provide health care to patients in New Mexico, including:

(1) an optometrist;

(2) a chiropractic physician;

(3) a dentist;

(4) a physician;

(5) a podiatrist;

(6) an osteopathic physician;

(7) a physician assistant;

(8) a certified nurse practitioner;

(9) a physical therapist;

(10) an occupational therapist;

(11) a speech-language pathologist;

(12) a doctor of oriental medicine;

(13) a nutritionist;

(14) a psychologist;

(15) a certified nurse-midwife;

(16) a clinical nurse specialist;

(17) a registered nurse;

(18) a dental hygienist;

(19) a pharmacist;

(20) a licensed independent social worker;

(21) a licensed counselor;

(22) a community health representative; or

(23) a licensed athletic trainer;

B. "originating site" means a place where a patient may receive health care via telehealth. An originating site may include:

(1) a licensed inpatient center;

(2) an ambulatory surgical or treatment center;

(3) a skilled nursing center;

(4) a residential treatment center;

(5) a home health agency;

(6) a diagnostic laboratory or imaging center;

(7) an assisted living center;

(8) a school-based health program;

(9) a mobile clinic;

(10) a mental health clinic;

(11) a rehabilitation or other therapeutic health setting;

(12) the patient's residence;

(13) a federally qualified health center; or

(14) a community health center; and

C. "telehealth" means the use of electronic information, imaging and communication technologies, including interactive audio, video, data communications as well as store-

and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education.

History: Laws 2004, ch. 48, § 3; 2007, ch. 203, § 3.

24-25-4. Telehealth authorized; procedure.

The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in New Mexico. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in telehealth pursuant to the New Mexico Telehealth Act. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality and privacy protections for health care information.

History: Laws 2004, ch. 48, § 4.

24-25-5. Scope of act.

A. The New Mexico Telehealth Act does not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

B. Because the use of telehealth improves access to quality health care and will generally benefit the citizens of New Mexico, health insurers, health maintenance organizations, managed care organizations and third-party payors offering services to the citizens of New Mexico are encouraged to use and provide coverage for telehealth within the scope of their plans or policies. The state's medical assistance program is also encouraged to include telehealth within the scope of its plan or policy.

History: Laws 2004, ch. 48, § 5; 2007, ch. 203, § 4.

ARTICLE 26
Patient Care Monitoring Act

24-26-1. Short title.

This act [24-26-1 to 24-26-12 NMSA 1978] may be cited as the "Patient Care Monitoring Act".

History: Laws 2004, ch. 53, § 1.

24-26-2. Definitions.

As used in the Patient Care Monitoring Act:

A. "department" means the aging and long-term services department;

B. "facility" means a long-term care facility licensed pursuant to the provisions of Section 24-1-5 NMSA 1978, other than an intermediate care facility for individuals with developmental or intellectual disabilities, and may also include:

(1) a skilled nursing facility;

(2) an intermediate care nursing facility;

(3) a nursing facility;

(4) an adult residential shelter care home;

(5) a boarding home;

(6) any adult care home or adult residential care facility; and

(7) any swing bed in an acute care facility or extended care facility;

C. "monitoring device" means a surveillance instrument that broadcasts or records activity, but does not include a still camera;

D. "patient" means a person who is a resident of a facility;

E. "program" means the New Mexico long-term care ombudsman program; and

F. "surrogate" means a legal guardian or a legally appointed substitute decision-maker who is authorized to act on behalf of a patient.

History: Laws 2004, ch. 53, § 2; 2023, ch. 113, § 2.

24-26-3. Monitoring device; authorization and use.

A. A patient or a surrogate may authorize installation and use of a monitoring device in a facility provided that:

(1) the facility is given notice of the installation;

(2) if the monitoring device records activity visually, such recording shall include a record of the date and time;

(3) the monitoring device and all installation and maintenance costs are paid for by the patient; and

(4) written consent is given by each patient or surrogate of each patient occupying the same room.

B. The patient may establish and the facility shall accommodate limits on the use, including the time of operation, direction, focus or volume, of a monitoring device.

History: Laws 2004, ch. 53, § 3.

24-26-4. Monitoring device option; installation; accommodation by facility.

A. At the time of admission to a facility, a patient shall be offered the option to have a monitoring device, and a record of the patient's authorization or choice not to have a monitoring device shall be kept by the facility and shall be made accessible to the program.

B. After authorization, consent and notice, a patient or surrogate may install, operate and maintain a monitoring device in the patient's room at the patient's expense.

C. The facility shall cooperate to accommodate the installation of the monitoring device, provided the installation does not place undue burden on the facility.

History: Laws 2004, ch. 53, § 4.

24-26-5. Consent; waiver.

A. Consent to the authorization for the installation and use of a monitoring device may be given only by the patient or the surrogate.

B. Consent to the authorization for the installation and use of a monitoring device shall include a release of liability for the facility for a violation of the patient's right to privacy insofar as the use of the monitoring device is concerned.

C. A patient or the surrogate may reverse a choice to have or not have a monitoring device installed and used at any time, after notice to the facility and to the program upon a form prescribed by the agency.

History: Laws 2004, ch. 53, § 5.

24-26-6. Authorization form; contents.

The form for the authorization of installation and use of a monitoring device shall provide for:

A. consent of the patient or the surrogate authorizing the installation and use of the monitoring device;

B. notice to the facility of the patient's installation of a monitoring device and specifics as to its type, function and use;

C. consent of any other patient or that patient's surrogate sharing the same room;

D. notice of release from liability for privacy violation through the use of the monitoring device; and

E. waiver of the patient's right to privacy in conjunction with the use of the monitoring device.

History: Laws 2004, ch. 53, § 6.

24-26-7. Immunity; unauthorized use.

A. In any civil action against the facility, material obtained through the use of a monitoring device may not be used if the monitoring device was installed or used without the knowledge of the facility or without the prescribed form.

B. Compliance with the provisions of the Patient Care Monitoring Act shall be a complete defense against any civil or criminal action brought against the patient, surrogate or facility for the use or presence of a monitoring device.

History: Laws 2004, ch. 53, § 7.

24-26-8. Notice to current patients.

Within six months of the effective date of the Patient Care Monitoring Act, all facilities shall provide to each patient or surrogate a form prescribed by the agency explaining the provisions of the Patient Care Monitoring Act and giving each patient or surrogate a choice to have a monitoring device installed in the patient's room. Copies of the completed form shall be kept by the facility and shall be made accessible to the program.

History: Laws 2004, ch. 53, § 8.

24-26-9. Notice.

The facility shall post a notice in a conspicuous place at the entrance to a room with a monitoring device that a monitoring device is in use in that room of the facility.

History: Laws 2004, ch. 53, § 9.

24-26-10. Rules.

The agency shall adopt rules necessary to implement the provisions of the Patient Care Monitoring Act.

History: Laws 2004, ch. 53, § 10.

24-26-11. Prohibited acts.

No person or patient shall be denied admission to or discharged from a facility or be otherwise discriminated against or retaliated against because of a choice to authorize installation and use of a monitoring device. Any person who violates this section shall be subject to the provisions of Section 28-17-19 NMSA 1978.

History: Laws 2004, ch. 53, § 11.

24-26-12. Criminal acts.

Any person other than a patient or surrogate found guilty of intentionally hampering, obstructing, tampering with or destroying a monitoring device or a recording made by a monitoring device installed in a facility pursuant to the Patient Care Monitoring Act is guilty of a fourth degree felony and shall be sentenced pursuant to Section 31-18-15 NMSA 1978.

History: Laws 2004, ch. 53, § 12.

ARTICLE 27
Umbilical Cord Blood Banking Act

24-27-1. Short title.

Chapter 24, Article 27 NMSA 1978 may be cited as the "Umbilical Cord Blood Banking Act".

History: Laws 2005, ch. 43, § 1; 2008, ch. 9, § 1.

24-27-2. Purpose of act.

The purpose of the Umbilical Cord Blood Banking Act is to educate pregnant women regarding the potential benefits of umbilical cord blood donations and to provide opportunities for the donation and storage of umbilical cord blood when desired by a pregnant woman.

History: Laws 2005, ch. 43, § 2.

24-27-3. Definitions.

As used in the Umbilical Cord Blood Banking Act:

A. "health care facility" means an institution providing health care services, including a hospital, clinic or other inpatient center, outpatient facility or diagnostic or treatment center, that is licensed by the department of health;

B. "health care provider" means a person who is licensed, certified or otherwise authorized by law to provide or render health care services to pregnant women in New Mexico in the ordinary course of business or practice of a profession, but is limited to a medical physician, osteopathic physician, doctor of oriental medicine, physician assistant, certified nurse practitioner and certified nurse-midwife; and

C. "umbilical cord blood" means the blood that remains in the umbilical cord and placenta after the birth of a newborn child.

History: Laws 2005, ch. 43, § 3; 2008, ch. 9, § 2.

24-27-4. Dissemination of information.

A. All health care providers providing health care services to a pregnant woman during the last trimester of her pregnancy, which health care services are directly related to her pregnancy, shall advise her of options to donate umbilical cord blood following the delivery of a newborn child. Provision in a timely manner of publications prepared by the department of health pursuant to Section 5 [24-27-5 NMSA 1978] of the Umbilical Cord Blood Banking Act shall constitute compliance with this subsection.

B. Nothing in this section imposes an obligation upon a health care provider to inform a pregnant woman regarding the option of umbilical cord blood donations if such information conflicts with bona fide religious beliefs of the health care provider.

History: Laws 2005, ch. 43, § 4.

24-27-5. Informational publications.

The department of health shall, by January 1, 2006, prepare and distribute to health care providers written publications that include the following information:

A. the medical processes involved in the collection of umbilical cord blood;

B. the medical risks to a mother and her newborn child of umbilical cord blood collection;

C. the current and potential future medical uses and benefits of umbilical cord blood collection to a mother, her newborn child and her biological family;

D. the current and potential future medical uses and benefits of umbilical cord blood collection to persons who are not biologically related to a mother or her newborn child;

E. any costs that may be incurred by a pregnant woman who chooses to make an umbilical cord blood donation;

F. options for ownership and future use of the donated material; and

G. the availability in this state of umbilical cord blood donations.

History: Laws 2005, ch. 43, § 5.

24-27-6. Donation of umbilical cord blood.

A. Unless it is medically inadvisable, all health care facilities and health care providers treating a pregnant woman during the delivery of a newborn child shall, if requested by that woman, permit her to arrange for an umbilical cord blood donation.

B. Nothing in this section imposes an obligation upon a health care facility or health care provider to permit an umbilical cord blood donation if in the professional judgment of a health care provider the donation of umbilical cord blood would threaten the health of the mother or newborn child.

C. Nothing in this section imposes an obligation upon a health care facility or health care provider to permit an umbilical cord blood donation if the donation conflicts with bona fide religious beliefs of the health care facility or health care provider. If a health care facility or health care provider declines to engage in umbilical cord blood donation, that fact shall be made known to pregnant patients of that facility or provider as soon as reasonably feasible.

History: Laws 2005, ch. 43, § 6.

24-27-7. Severability.

If any part or application of the Umbilical Cord Blood Banking Act is held invalid, the remainder or its application to other situations or persons shall not be affected.

History: Laws 2005, ch. 43, § 7.

ARTICLE 28
Bone Marrow and Organ Donor Act

24-28-1. Short title.

Chapter 24, Article 28 NMSA 1978 may be cited as the "Bone Marrow and Organ Donor Act".

History: Laws 2007, ch. 159, § 1; 2019, ch. 112, § 1.

24-28-2. Public education.

A. The department of health shall provide information and educational materials to the public regarding bone marrow donation through the national marrow donor program and regarding organ donations. The department shall seek assistance from the national marrow donor program to establish a system to distribute materials, ensure that the materials are updated periodically, fully disclose the risks involved in donating bone marrow and address the education and recruitment of minority populations.

B. The information and educational materials shall include information on:

(1) the need for bone marrow donations;

(2) patient populations that would benefit from bone marrow donations;

(3) how to join the bone marrow registry; and

(4) how to acquire a free buccal swab kit from the bone marrow registry.

C. The department shall establish a system to distribute information and educational materials regarding organ donations and ensure that the materials are updated periodically, fully disclose the risks of donating an organ and address the education and recruitment of minority populations.

History: Laws 2007, ch. 159, § 2; 2019, ch. 112, § 2.

24-28-3. State employee leave.

A. The person in charge of a state agency may grant a leave of absence, not to exceed twenty days, to a state agency employee for the purpose of donating an organ or bone marrow. An employee may request and use donated annual leave or sick leave for the purpose of donating an organ or bone marrow. If an employee requests donations of sick leave or annual leave but does not receive the full amount of leave needed for the donation of an organ or bone marrow, the person in charge of a state agency may grant a paid leave of absence for the remainder of the needed leave up to the maximum total of twenty workdays. The person in charge of a state agency may require verification by a physician regarding the purpose of the leave requested and information from the physician regarding the length of the leave requested. Any paid leave of absence granted pursuant to this section shall not result in a loss of compensation, seniority, annual leave, sick leave or accrued overtime for which the employee is otherwise eligible.

B. For the purposes of this section, "state agency" means any department, institution, board, bureau, commission, district or committee of government of the state of New Mexico.

History: Laws 2007, ch. 159, § 3.

ARTICLE 29
Hospital-Acquired Infection

24-29-1. Short title.

This act [Chapter 24, Article 29 NMSA 1978] may be cited as the "Hospital-Acquired Infection Act".

History: Laws 2009, ch. 211, § 1.

24-29-2. Definitions.

As used in the Hospital-Acquired Infection Act:

A. "advisory committee" means the hospital-acquired infection advisory committee;

B. "department" means the department of health;

C. "hospital-acquired infection" means a localized or systemic condition that results from an infection that occurs in a hospital that was not present or incubating at the time of admission as an inpatient to the hospital, unless the infection was related to a previous admission to the same setting, and that meets the criteria for a specific infection as defined by the national healthcare safety network;

D. "indicator" means a measure of a hospital-acquired infection or other condition, process or serious reportable event identified and defined by the advisory committee that is based on objective, scientific standards and that may be tracked and reported;

E. "national healthcare safety network" means the secure, internet-based surveillance system that integrates patient and health care personnel safety managed by the centers for disease control and prevention of the federal department of health and human services;

F. "participating hospital" means a hospital that meets the criteria specified by the advisory committee or that desires to participate in hospital-acquired infection surveillance; and

G. "surveillance system" means a secure, internet-based system designed for the collection of hospital-acquired infection incidence and prevention data.

History: Laws 2009, ch. 211, § 2.

24-29-3. Advisory committee created; members; duties.

A. The "hospital-acquired infection advisory committee" is created in the department to conduct surveillance of hospital-acquired infections. Members of the advisory committee shall include:

(1) a consumer of health care services;

(2) a representative of the New Mexico association for professionals in infection control and epidemiology;

(3) a representative of the New Mexico hospital association;

(4) a representative of the New Mexico medical review association;

(5) a local representative of the society for healthcare epidemiology of America; and

(6) the department's infectious disease epidemiology bureau.

B. The advisory committee shall:

(1) establish objectives, definitions, criteria and standards for the reporting of hospital-acquired infections;

(2) work with hospitals to identify and recruit volunteer participating hospitals in surveillance of hospital-acquired infections and other indicators;

(3) develop objectives and action plans for instituting a statewide program of surveillance of hospital-acquired infections and other indicators;

(4) identify the specific infections and indicators that are to be subject to surveillance and reporting;

(5) identify, and make recommendations regarding, training in the use of the surveillance system or in the prevention and control of hospital-acquired infections and infectious disease;

(6) develop and disseminate to the public appropriate reports of the findings of surveillance; and

(7) consult as necessary with technical advisors who have regional or national expertise in the prevention and control of hospital-acquired infections and infectious disease.

History: Laws 2009, ch. 211, § 3.

24-29-4. Participating hospitals; recruitment; training.

A. The advisory committee shall identify hospitals willing and qualified to participate in surveillance of hospital-acquired infections as identified by the advisory committee. Recruitment of participating hospitals shall begin on a voluntary basis and shall include at least six hospitals representing rural and urban areas of the state. By July 1, 2011, the hospitals identified by the advisory committee as qualified shall participate in the surveillance program.

B. The advisory committee shall identify specific training and educational needs of participating hospitals, and the department shall develop curricula to reflect the training and educational recommendations of the advisory committee. The department shall provide training and educational support to participating hospitals subject to available resources. The department shall collaborate with the higher education department to identify appropriate programs for training and certification of infection control professionals.

History: Laws 2009, ch. 211, § 4.

24-29-5. Hospital-acquired infections; indicators.

A. The advisory committee shall determine the specific infections and indicators that are to be subject to surveillance and reporting. Indicators of hospital-acquired infections shall be selected based on scientific evidence that the infection or condition can be prevented with implementation and consistent use of evidence-based processes of care and on appropriateness for the state. The advisory committee shall consider the following indicators:

(1) central line associated bloodstream infections;

(2) surgical site wound infections;

(3) ventilator assisted pneumonia;

(4) catheter associated urinary tract infections; and

(5) other hospital-acquired infections that the advisory committee may determine in consultation with technical advisors who are regionally or nationally recognized experts in the prevention, identification and control of hospital-acquired infections and the public reporting of performance data.

B. Initially, and through calendar year 2009, hospital-acquired infection surveillance shall be conducted on the incidence of central line associated bloodstream infections and health care worker influenza vaccination rates.

C. Beginning on January 1, 2010, the advisory committee shall identify additional hospital-acquired infection, condition or process indicators that will be tracked and reported by participating hospitals. At least annually, the advisory committee shall consider additional indicators that meet the standard for selection identified in Subsection A of this section.

History: Laws 2009, ch. 211, § 5.

24-29-6. Reports.

A. Participating hospitals shall report to the department the incidence of selected indicators using the national healthcare safety network surveillance system according to a schedule recommended by the advisory committee based on reporting frequencies identified by the national healthcare safety network. Reported data shall be verifiable and actionable.

B. The advisory committee shall determine the content, format, venue and frequency of regular reports to the public. Public reports shall be published no later than July 1, 2011 and periodically thereafter.

History: Laws 2009, ch. 211, § 6.

ARTICLE 30
Community Health Workers

24-30-1. Short title.

This act [24-30-1 to 24-30-7 NMSA 1978] may be cited as the "Community Health Workers Act".

History: Laws 2014, ch. 49, § 1.

24-30-2. Definitions.

As used in the Community Health Workers Act:

A. "applicant" means an individual applying to be certified or recertified as a community health worker;

B. "board" means the board of certification of community health workers;

C. "certificate" means the document issued by the department to qualified applicants for certification as community health workers;

D. "certification" means the voluntary process by which the department grants recognition and use of a credential to individuals who are eligible to practice as certified community health workers;

E. "certified community health worker" means a community health worker to whom the department has issued a certificate to practice as a certified community health worker;

F. "community health worker" means a public health worker who applies an understanding of the experience, language and culture of the populations that the individual serves and who provides direct services aimed at optimizing individual and family health outcomes, including:

(1) informal and motivational counseling and education;

(2) interventions to maximize social supports;

(3) care coordination;

(4) facilitation of access to health care and social services;

(5) health screenings; and

(6) other services that the secretary defines by rule;

G. "department" means the department of health;

H. "recertification" means a renewal of certification; and

I. "secretary" means the secretary of health.

History: Laws 2014, ch. 49, § 2.

24-30-3. Rulemaking; community health worker certification; recertification; fees.

A. The secretary shall adopt and promulgate rules relating to the following:

(1) establishment and administration of a voluntary program for certification of community health workers, including criteria for:

(a) minimum education;

(b) training;

(c) experience; and

(d) other qualifications that the secretary deems appropriate in accordance with the provisions of the Community Health Workers Act;

(2) forms and procedures for the receipt, review and action upon applications for initial community health worker certification and for biennial recertification;

(3) establishment of standards for continuing education and other requirements that the secretary deems appropriate for biennial recertification;

(4) procedures for disciplinary action relating to applicants or certified community health workers. Department rules shall include guidelines for:

(a) disciplinary action;

(b) reprimands;

(c) probation;

(d) the denial, suspension or revocation of certification or recertification; and

(e) applicants' appeal rights;

(5) the determination, assessment and collection of certification fees, recertification fees and disciplinary fines; and

(6) other matters that the secretary deems appropriate to carry out the provisions of the Community Health Workers Act.

B. The department shall apply any fee it collects pursuant to the Community Health Workers Act to cover the costs of administering the community health worker certification program established pursuant to that act.

History: Laws 2014, ch. 49, § 3.

24-30-4. Board of certification of community health workers; creation; membership; duties.

A. The "board of certification of community health workers" is created. The board is administratively attached to the department and shall meet at least once quarterly at the call of the chair.

B. The board shall consist of nine members who shall be:

(1) residents of the state;

(2) appointed by and serve at the pleasure of the secretary; and

(3) composed of:

(a) the secretary or the secretary's designee, who shall serve as chair of the board; and

(b) eight additional members, at least three of whom shall be community health workers.

C. In determining the membership of the board, the secretary shall endeavor to appoint community health worker stakeholders such as health care providers, individuals from institutions of higher learning and members of the community from various geographic regions of the state.

D. The secretary shall adopt and promulgate rules that establish the board's membership, duties and the conduct of meetings. At a minimum, the board's duties shall include making recommendations to the secretary on the following matters:

(1) standards and requirements for the establishment of community health worker education and training programs in the state, the successful completion of which shall qualify an individual as eligible to apply to the department for certification as a certified community health worker;

(2) standards and requirements for approval or acceptance of continuing education courses and programs as the board may require for the biennial renewal of a community health worker certificate;

(3) minimum education, training, experience and other qualifications that a certified community health worker shall possess to qualify as a trainer in any education, training or continuing education program for community health workers;

(4) a means to acknowledge, document and assess relevant education, training and experience or other qualifications acquired by community health workers practicing in the state before the effective date of the Community Health Workers Act for purposes of certification while waiving minimum training and experience requirements established pursuant to Paragraph (1) of Subsection A of Section 3 [24-30-3 NMSA 1978] of the Community Health Workers Act; and

(5) the type of certification examination or other means to assess community health worker competency in connection with certification that the department shall require if the secretary determines that a certification examination would enhance the advancement of the practice and profession of community health workers.

History: Laws 2014, ch. 49, § 4.

24-30-5. Requirements for certification; recertification.

A. An applicant for certification or recertification shall submit an application for registration in accordance with department rules.

B. A certified community health worker shall carry the certified community health worker's certificate and present it upon request.

C. The department shall issue certificates that shall be valid for two years to certified community health workers. A certificate may be recertified in accordance with department rules.

History: Laws 2014, ch. 49, § 5.

24-30-6. Use of certified community health worker designation; unauthorized practice.

A. In order to use the title "certified community health worker", the initials "CCHW" or other designation indicating that the individual is a certified community health worker, an individual shall be certified pursuant to the provisions of the Community Health Workers Act.

B. To ensure compliance with the provisions of the Community Health Workers Act or any rule that the secretary has adopted and promulgated pursuant to that act, the department may issue cease-and-desist orders to persons violating the provisions of the Community Health Workers Act.

C. A certified community health worker shall engage only in those activities authorized pursuant to the Community Health Workers Act and by rules adopted and promulgated pursuant to that act. While engaging in practice as a certified community health worker, an individual shall not engage in or perform any act or service for which another professional certificate, license or other legal authority is required. Nothing in this section shall be construed to prevent or restrict the practice, service or activities of any individual simultaneously certified as a community health worker and licensed, certified, registered or otherwise legally authorized in the state to engage in the practice of another profession if that individual does not, while engaged in the authorized practice of another profession, use any name, title, the initials "CCHW" or other designation indicating that the individual is a certified community health worker.

History: Laws 2014, ch. 49, § 6.

24-30-7. Criminal history screening.

A. The department is authorized to obtain the criminal history records of applicants and to exchange fingerprint data directly with the federal bureau of investigation, the department of public safety and any other law enforcement agency or organization. The department shall require fingerprinting of applicants for the purposes of this section.

B. The secretary shall adopt and promulgate rules to:

(1) require criminal background checks for applicants;

(2) identify the information from a criminal background check that may form the basis of a denial, suspension or revocation of certification or any other disciplinary action; and

(3) otherwise carry out the provisions of this section.

C. The department shall comply with applicable confidentiality requirements of the department of public safety and the federal bureau of investigation regarding the dissemination of criminal background check information.

D. An applicant whose certification or recertification is denied, suspended or revoked, or who is otherwise disciplined based on information obtained in a criminal history background check, shall be entitled to review the information obtained pursuant to this section and to appeal the decision pursuant to rules promulgated by the department.

E. The applicant shall bear any costs associated with ordering or conducting criminal background checks.

F. The provisions of the Criminal Offender Employment Act [28-2-1 to 28-2-6 NMSA 1978] shall govern any consideration of criminal records required or permitted by the Community Health Workers Act.

History: Laws 2014, ch. 49, § 7.

ARTICLE 31
Emergency Medication In Schools

24-31-1. Emergency medication in schools; albuterol; epinephrine; rules; recommendations.

A. By July 1, 2014, the department shall promulgate rules and make recommendations to each school district and governing body of a school for the prevention and treatment of respiratory distress and the administration of albuterol, or such other medication as the department deems appropriate, by a school nurse.

B. By July 1, 2014, the department shall promulgate rules and make recommendations to each school district and governing body of a school for the prevention and treatment of anaphylaxis occurring in schools and for the use of epinephrine, or such other medication as the department deems appropriate, by a person who has received training approved by the department and is authorized to

administer epinephrine pursuant to the Emergency Medication in Schools Act [22-33-1 to 22-33-4 NMSA 1978]. The rules shall address:

(1) the provision or administration of epinephrine, or such other medication as the department deems appropriate, to a person reasonably believed to be having an anaphylactic reaction;

(2) the requirement that one or more trained persons be available on school premises during operating hours to treat a person reasonably believed to be having an anaphylactic reaction;

(3) the maintenance of a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors, or such other medication as the department deems appropriate, pursuant to a standing order prescribed in the name of the school or school district by a health care practitioner employed or authorized by the department;

(4) the storage of a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors, or such other medication as the department deems appropriate, in a secure location that is unlocked and readily accessible to trained persons and stored pursuant to board of pharmacy regulations; and

(5) the disposal of expired emergency medication pursuant to board of pharmacy regulations or department rules.

C. A health care practitioner employed or authorized by the department may prescribe a stock supply of albuterol aerosol canisters and spacers or a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors in the name of a school or school district for use in accordance with the Emergency Medication in Schools Act.

D. A pharmacist may dispense a stock supply of albuterol aerosol canisters and spacers or a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors pursuant to a standing order prescribed in accordance with this section.

E. A school or school district may maintain a stock supply of albuterol aerosol canisters and spacers or a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors for use in accordance with this section.

F. The department may obtain and receive grants, appropriations, gifts and donations from any source, including the acceptance of epinephrine and albuterol, or such other medication as the department deems appropriate, and albuterol spacers from a manufacturer or wholesaler of such medication in accordance with this section.

History: Laws 2014, ch. 50, § 5.

ARTICLE 32
Maternal Mortality and Morbidity Prevention

24-32-1. Short title.

Chapter 24, Article 32 NMSA 1978 may be cited as the "Maternal Mortality and Morbidity Prevention Act".

History: Laws 2019, ch. 41, § 1; 2021, ch. 40, § 1.

24-32-2. Definitions.

As used in the Maternal Mortality and Morbidity Prevention Act:

A. "administrative co-chair" means the chief medical officer of the department or another representative of the department appointed by the secretary of health;

B. "aggregate data" means health care data that exclude any individually identifiable health information, including patient and health care provider identification;

C. "chief medical officer" means the chief medical officer of the department;

D. "clinical co-chair" means a committee member with maternal child health clinical or paraprofessional training nominated by the committee and approved by the department to serve in this position;

E. "committee" means the maternal mortality review committee;

F. "committee member" means a person who has been appointed to sit as a member of the committee and who participates in committee business and votes on committee matters;

G. "critical income" means income lost as a result of uncompensated work time used to attend a committee meeting;

H. "de-identified data" means data from which the following identifiers have been removed:

(1) names;

(2) any geographic subdivision smaller than a state, including street address, city, county, precinct and zip code and their equivalent geocodes;

(3) all elements of dates, except the year of an incident, that are directly related to an individual, including birth date, admission date, date of delivery, discharge date and date of death;

(4) telephone numbers;

(5) fax numbers;

(6) electronic mail addresses;

(7) social security numbers;

(8) medical record numbers;

(9) health plan beneficiary numbers;

(10) account numbers;

(11) certificate and license numbers;

(12) vehicle identifiers and serial numbers, including license plate numbers;

(13) device identifiers and serial numbers;

(14) web universal resource locators, also known as "URLs";

(15) internet protocol address numbers;

(16) biometric identifiers, including finger and voice prints;

(17) full-face photographic images and any comparable images; and

(18) any other unique identifying number, characteristic or code;

I. "department" means the department of health;

J. "health care provider" means:

(1) an individual licensed, certified or otherwise authorized to provide health care services in the ordinary course of business in the state; or

(2) a health facility that the department licenses;

K. "law enforcement agency" means a law enforcement agency of the state, an Indian nation, tribe or pueblo or a political subdivision of the state;

L. "maternal mortality" means the death of a pregnant woman or a woman within one year postpartum;

M. "medical record" means the written or graphic documentation, sound recording or electronic record relating to medical, behavioral health and health care services that a patient receives from a health care provider or under the direction of a physician or another licensed health care provider. "Medical record" includes diagnostic documentation, including an x-ray, electrocardiogram and electroencephalogram; other test results; data entered into a prescription drug monitoring program; and an autopsy report;

N. "operational staff" means staff or contractors of the department assigned or contracted to support the work of the committee or its executive committee;

O. "qualified invited guest" means a person approved by the co-chairs and invited by the committee to attend a committee meeting to provide technical expertise to the committee, to enhance training in maternal health, to provide insight on maternal mortality or severe maternal morbidity review in other jurisdictions or to provide operational support to the committee; and

P. "severe maternal morbidity" means unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health as identified by hospitalizations using administrative hospital discharge data and the world health organization's *International Classification of Diseases* diagnosis and procedure codes.

History: Laws 2019, ch. 41, § 2; 2021, ch. 40, § 2.

24-32-3. Maternal mortality review committee; creation; membership; duties.

A. The "maternal mortality review committee" is created in the department. The committee shall be composed of:

(1) the chief medical officer of the department or another representative of the department appointed by the secretary of health, who shall be the ex-officio administrative co-chair;

(2) a clinical co-chair, who shall be nominated by the committee and approved by the department; and

(3) a maximum of thirty additional members, who shall be appointed by the administrative co-chair; provided that four of those members shall include:

(a) two members nominated by the secretary of Indian affairs; and

(b) two members nominated by the director of the office on African American affairs.

B. Each member of the committee, except the administrative co-chair, shall serve a term of three years, with no consecutive terms.

C. Pursuant to requirements established by the department, each member of the committee shall receive training on trauma and the impacts of trauma, including secondary trauma, trauma of racism and trauma of maternal mortality and morbidity.

D. In appointing members of the committee, the administrative co-chair shall include members that work in and represent communities that are most impacted per the state maternal mortality ratio so that the composition of the committee reflects:

(1) the racial, ethnic and linguistic diversity of the state;

(2) the differing geographic regions within the state, including rural and urban areas; and

(3) communities that are most impacted by pregnancy-related deaths, severe maternal morbidity and a lack of access to relevant perinatal and intrapartum care services.

E. The committee shall meet at the call of the co-chairs. A majority of committee members appointed constitutes a quorum for the transaction of any business. The affirmative vote of at least a majority of a quorum present and approval by the secretary of health or the secretary's designee shall be necessary for any action to be taken by the committee. No vacancy in the membership of the committee shall impair the right of a quorum to exercise all rights and perform all duties of the committee.

F. Operational staff and qualified guests may participate in committee deliberations in an advisory capacity as directed by the co-chairs of the committee. Operational staff and qualified guest presence at a committee meeting shall not convey committee membership.

G. A committee member required to travel in excess of fifty miles to attend a meeting of the committee may, with the approval of the department, receive per diem and mileage for attendance at that meeting pursuant to the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978]. A committee member forsaking critical income to attend a committee meeting may, with the approval of the department and pursuant to rules established by the department, be additionally reimbursed for loss of that income in an amount not to exceed three hundred dollars ($300) per meeting.

H. The committee shall:

(1) review each incident of maternal mortality using a de-identified case summary prepared by operational staff;

(2) review aggregate data relating to severe maternal morbidity;

(3) outline trends and patterns and provide recommendations relating to maternal mortality and severe maternal morbidity in the state;

(4) compile reports using aggregate data on an annual basis in an effort to further study the causes and problems associated with maternal mortality and severe maternal morbidity and distribute these reports to the legislature, government agencies, including the Indian Affairs department and the office on African American affairs, health care providers, community-based organizations working in the interest of maternal and child health and others as necessary to reduce the maternal mortality rate in the state. These reports shall include recommendations to assist health care providers and the health care system in reducing maternal mortality and morbidity;

(5) serve as a link with maternal mortality and morbidity review teams nationwide and participate in national maternal mortality and morbidity review team activities; and

(6) perform any other functions as resources allow to enhance efforts to reduce and prevent maternal mortality and severe maternal morbidity in the state.

I. The co-chairs of the committee may designate an executive committee to conduct business as necessary. The executive committee shall:

(1) consist of the co-chairs of the committee and any other committee members or operational staff that the co-chairs deem necessary. Operational staff and qualified guests may participate in executive committee deliberations in an advisory capacity as directed by the co-chairs of the committee. Operational staff and qualified guest presence at an executive committee meeting shall not convey committee membership;

(2) meet at the call of the co-chairs;

(3) monitor and support the activities of the full committee and recruit committee members for recommendation to the administrative co-chair; and

(4) make final decisions regarding:

(a) committee operations and rules;

(b) data analysis, data dissemination and evaluation based on findings and recommendations from the full committee; and

(c) any other issues within the scope of decisions that may be made by the committee pursuant to the Maternal Mortality and Morbidity Prevention Act that the full committee or department deems necessary.

History: Laws 2019, ch. 41, § 3; 2021, ch. 40, § 3.

24-32-4. Access to health information.

A. A health care provider, the office of the state medical investigator and the vital records and health statistics bureau of the department shall notify operational staff of any incident of maternal mortality within three months of the incident.

B. Except as otherwise provided by law, the clinical co-chair and operational staff may access medical records and other health information relating to an incident of maternal mortality at any time within five years from the date of the incident. At the request of the clinical co-chair or operational staff with co-chairs or department approval, a health care provider, the office of the state medical investigator and the vital records and health statistics bureau of the department shall provide medical records and other requested health information to the department relating to an incident of maternal mortality. Upon the request of the clinical co-chair or operational staff, a law enforcement agency shall provide any report relating to an incident of maternal mortality to the department. A health care provider or law enforcement agency that provides a medical record, health information or report pursuant to this section with reasonable care and in compliance with the law shall not be held criminally or civilly liable for that release of information.

C. The following shall be confidential and shall not be subject to the Open Meetings Act [Chapter 10, Article 15 NMSA 1978] or the Inspection of Public Records Act [Chapter 14, Article 3 NMSA 1978] or subject to any subpoena, discovery request or introduction into evidence in a civil or criminal proceeding unless obtained from a source separate and apart from the committee or department by valid means as provided by law:

(1) any meeting, part of a meeting or activity of the committee or its executive committee at which data or other information is to be discussed and that may result in disclosure to the public of information protected by law; and

(2) except as may be necessary in furtherance of the duties of the committee or in response to an alleged violation of a confidentiality agreement pursuant to Subsection E of this section, any information, record, report, notes, memorandum or other data that the department or committee obtains pursuant to the Maternal Mortality and Morbidity Prevention Act.

D. Only the clinical co-chair and operational staff shall collect and have access to medical records, law enforcement reports and vital records data to support the work of the full committee.

E. Each committee member and qualified guest shall sign a confidentiality agreement that indicates the member's or qualified guest's adherence to the provisions of this section.

History: Laws 2019, ch. 41, § 4; 2021, ch. 40, § 4.

24-32-5. Rulemaking.

By December 31, 2021, the secretary of health shall adopt and promulgate amended rules to carry out the provisions of the Maternal Mortality and Morbidity Prevention Act.

History: Laws 2019, ch. 41, § 5; 2021, ch. 40, § 5.

ARTICLE 33
Graduate Medical Education Expansion Grant Program (Recompiled.)

24-33-1. Recompiled.

History: Laws 2019, ch. 141, § 1; § 24-33-1, recompiled and amended as § 24A-7-1 by Laws 2024, ch. 39, § 53.

24-33-2. Recompiled.

History: Laws 2019, ch. 141, § 2; § 24-33-2, recompiled and amended as § 24A-7-2 by Laws 2024, ch. 39, § 54.

24-33-3. Recompiled.

History: Laws 2019, ch. 141, § 3; § 24-33-3, recompiled and amended as § 24A-7-3 by Laws 2024, ch. 39, § 55.

24-33-4. Recompiled.

History: Laws 2019, ch. 141, § 4; § 24-33-4, recompiled and amended as § 24A-7-4 by Laws 2024, ch. 39, § 56.

ARTICLE 34
Reproductive and Gender-Affirming Health Care Freedom

24-34-1. Short title.

This act [24-34-1 to 24-34-5 NMSA 1978] may be cited as the "Reproductive and Gender-Affirming Health Care Freedom Act".

History: Laws 2023, ch. 11, § 1.

24-34-2. Definitions.

As used in the Reproductive and Gender-Affirming Health Care Freedom Act:

A. "gender-affirming health care" means psychological, behavioral, surgical, pharmaceutical and medical care, services and supplies provided to support a person's gender identity;

B. "public body" means a state or local government, an advisory board, a commission, an agency or an entity created by the constitution of New Mexico or any branch of government that receives public funding, including political subdivisions, special tax districts, school districts and institutions of higher education; and

C. "reproductive health care" means psychological, behavioral, surgical, pharmaceutical and medical care, services and supplies that relate to the human reproductive system, including services related to:

(1) preventing a pregnancy;

(2) abortion;

(3) managing a pregnancy loss;

(4) prenatal, birth, perinatal and postpartum health;

(5) managing perimenopause and menopause;

(6) managing fertility;

(7) treating cancers of the reproductive system; or

(8) preventing or treating sexually transmitted infections.

History: Laws 2023, ch. 11, § 2.

24-34-3. Public body prohibited action.

A. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not discriminate against a person based on that person's use of or refusal to use reproductive health care or gender-affirming health care services.

B. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not deny, restrict or interfere with a person's ability to access or provide reproductive health care or gender-affirming health care within the medical standard of care.

C. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not deprive, through prosecution, punishment or other means, a person's ability to act or refrain from acting during the person's pregnancy based on the potential, actual or perceived effect on the pregnancy.

D. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not impose or continue in effect any law, ordinance, policy or regulation that violates or conflicts with the provisions of the Reproductive and Gender-Affirming Health Care Freedom Act.

E. Nothing in the Reproductive and Gender-Affirming Health Care Freedom Act shall be construed to require a health care provider or entity to provide care:

(1) that the health care provider or entity does not otherwise provide or have a duty to provide under state or federal law;

(2) when the provision of service is against the medical judgment of the treating health care provider while acting within the standard of care; or

(3) when an individual does not provide payment or a source of payment for the service when it is required in the ordinary course of business, unless the health care provider has a duty to provide services under state or federal law, regardless of the ability to pay.

F. Nothing in the Reproductive and Gender-Affirming Health Care Freedom Act shall be construed to require a managed care organization or health insurance company to cover claims that are not otherwise required to be covered by the terms and conditions of an insurance contract, managed care contract or state or federal law.

History: Laws 2023, ch. 11, § 3.

24-34-4. Enforcement; penalties.

A. The attorney general or a district attorney may institute a civil action in district court if the attorney general or district attorney has reasonable cause to believe that a violation has occurred or to prevent a violation of the Reproductive and Gender-Affirming Health Care Freedom Act from occurring.

B. In any action brought under Subsection A of this section, the court may award appropriate relief, including temporary, preliminary or permanent injunctive relief. The court may assess a civil penalty for a violation of the Reproductive and Gender-

Affirming Health Care Freedom Act in the amount of five thousand dollars ($5,000) or actual damages resulting from each violation, whichever is greater.

C. Claims pursuant to the Reproductive and Gender- Affirming Health Care Freedom Act may be brought against public bodies and entities acting in the course and scope of authority of a public body, but not against an individual.

History: Laws 2023, ch. 11, § 4.

24-34-5. Private right of action.

A. A person claiming to be aggrieved by a violation of the Reproductive and Gender-Affirming Health Care Freedom Act may maintain an action in district court for appropriate relief, including temporary, preliminary or permanent injunctive relief, compensatory damages or punitive damages, or the sum of five thousand dollars ($5,000) for each violation of the Reproductive and Gender-Affirming Health Care Freedom Act, whichever is greater.

B. In any action brought pursuant to Subsection A of this section, the court shall award a prevailing plaintiff reasonable attorney fees and costs to be paid by the defendant.

C. Claims pursuant to the Reproductive and Gender-Affirming Health Care Freedom Act may be brought against public bodies and entities acting in the course and scope of authority of a public body, but not against an individual.

History: Laws 2023, ch. 11, § 5.

ARTICLE 35
Reproductive and Gender-Affirming Health Care Protection

24-35-1. Short title.

Sections 1 through 8 [24-35-1 to 24-35-8 NMSA 1978] of this act may be cited as the "Reproductive and Gender-Affirming Health Care Protection Act".

History: Laws 2023, ch. 167, § 1.

24-35-2. Definitions.

As used in the Reproductive and Gender-Affirming Health Care Protection Act:

A. "gender-affirming health care" means psychological, behavioral, surgical, pharmaceutical and medical care, services and supplies provided to support an individual's gender identity;

B. "protected health care activity" means:

(1) seeking, providing or receiving reproductive or gender-affirming health care; or

(2) assisting an individual who is seeking, receiving or providing reproductive or gender-affirming health care, including providing:

(a) information;

(b) transportation;

(c) lodging; or

(d) material support;

C. "public body" means a state or local government, an advisory board, a commission, an agency or an entity created by the constitution of New Mexico or a branch of government that receives public funding, including political subdivisions, special tax districts, school districts and institutions of higher education; and

D. "reproductive health care" means psychological, behavioral, surgical, pharmaceutical and medical care, services and supplies that relate to the human reproductive system, including services related to:

(1) preventing a pregnancy;

(2) abortion;

(3) managing a pregnancy loss;

(4) prenatal, birth, perinatal and postpartum health;

(5) managing perimenopause and menopause;

(6) managing infertility;

(7) treating cancers of the reproductive system; or

(8) preventing sexually transmitted infections.

History: Laws 2023, ch. 167, § 2.

24-35-3. Public body; prohibited release of information related to a protected health care activity.

A. A public body or an individual or entity acting on behalf of or within the scope of the authority of a public body shall not release information or use resources available to it in furtherance of a foreign investigation or proceeding that seeks to impose civil or criminal liability or professional disciplinary action upon an individual or entity for engaging in a protected health care activity.

B. A public body or an individual or entity acting on behalf of or within the scope of the authority of a public body that receives a request for information related to a protected health care activity shall notify the individual or entity that is the subject of the information request and shall move to modify or quash the subpoena to prevent the release of protected health care activity information. Any request for information related to a protected health care activity shall be made in writing.

C. The provisions of this section shall not apply if the individual or entity that is the subject of the investigation or proceeding provides affirmative written consent to release the requested information.

D. This section shall not apply to an investigation or proceeding in which the conduct subject to potential liability would be subject to liability under the laws of this state.

History: Laws 2023, ch. 167, § 3.

24-35-4. Foreign subpoenas and summonses.

A. A party shall not submit a foreign subpoena or summons for discovery or a witness to provide testimony related to an interstate investigation or proceeding that seeks to impose civil or criminal liability or professional disciplinary action related to a protected health care activity unless the requesting party submits an attestation, signed under the penalty of perjury, that the foreign subpoena or summons relates to an out-of-state action for which the same claim exists under the laws of this state.

B. An individual or entity served with a subpoena that is in violation of this section shall notify the issuing court and the moving party of the defect and shall not comply with the subpoena until the defect is cured by order of the issuing court.

C. A party that omits or submits a false attestation pursuant to this section shall be subject to the jurisdiction of the courts of this state in a suit for damages, penalties or both arising out of the omission or false attestation. A court shall assess a statutory penalty of ten thousand dollars ($10,000) per violation if the court finds the omission or false attestation was made intentionally, knowingly, willingly or recklessly.

History: Laws 2023, ch. 167, § 4.

24-35-5. Abusive litigation; interference with a protected health care activity; civil actions.

A. For purposes of this section, "abusive litigation" means legal action initiated to deter, prevent, sanction or penalize an individual or entity for engaging in a protected health care activity by initiating a legal action in another state where civil or criminal liability is based on engaging in a protected health care activity in this state or attempting to enforce an order or judgment issued in connection with such legal action.

B. An individual or entity claiming to be aggrieved by abusive litigation may file an action in district court and seek relief pursuant to Section 8 [24-35-8 NMSA 1978] of the Reproductive and Gender-Affirming Health Care Protection Act, as well as the amount of a judgment issued in connection with the abusive litigation.

C. This section shall not apply to a lawsuit or judgment entered in another state that is based on conduct for which a cause of action exists under the laws of New Mexico.

History: Laws 2023, ch. 167, § 5.

24-35-6. Heightened protection for electronically transmitted information related to a protected health care activity.

A. For purposes of this section, "third party" means an individual or entity who transmits information related to a protected health care activity, in the normal course of business, in an electronic format. "Third party" does not mean a covered entity or business associate as defined by the federal Health Insurance Portability and Accountability Act of 1996 and related regulations.

B. It shall be a violation of the Reproductive and Gender-Affirming Health Care Protection Act to request from a third party, or for a third party to transmit, information related to an individual's or entity's protected health care activity with the intent to:

(1) harass, humiliate or intimidate that individual or entity;

(2) incite another to harass, humiliate or intimidate that individual or entity;

(3) cause that individual to reasonably fear for that individual's own or family members' safety;

(4) cause that individual to suffer unwanted physical contact or injury;

(5) cause that individual to suffer substantial emotional distress; or

(6) deter, prevent, sanction or penalize an individual or entity for engaging in a protected health care activity.

C. This section shall not apply to a lawsuit or judgment entered in another state that is based on conduct for which a cause of action exists under the laws of New Mexico.

History: Laws 2023, ch. 167, § 6.

24-35-7. Enforcement; penalties.

A. The attorney general or a district attorney is authorized to enforce the provisions of the Reproductive and Gender-Affirming Health Care Protection Act.

B. In an action brought under Subsection A of this section, the court may award appropriate relief, including temporary, preliminary or permanent injunctive relief. The court may also assess a civil penalty for a violation of the Reproductive and Gender-Affirming Health Care Protection Act in the amount of ten thousand dollars ($10,000) or actual damages resulting from each violation, whichever is greater.

History: Laws 2023, ch. 167, § 7.

24-35-8. Private right of action.

A. An individual or entity claiming to be aggrieved by a violation of the Reproductive and Gender-Affirming Health Care Protection Act may file an action in district court for appropriate relief, including temporary, preliminary or permanent injunctive relief, compensatory damages or punitive damages, or for the sum of ten thousand dollars ($10,000) per violation, whichever is greater. Claims may be brought against a public body or third party that intentionally, knowingly, willingly or recklessly released information related to a protected health care activity.

B. In an action brought pursuant to Subsection A of this section, the district court shall award a prevailing plaintiff reasonable attorney fees and costs.

History: Laws 2023, ch. 167, § 8.