



UNDERSTANDING CONFIDENTIALITY AND MINOR CONSENT IN CALIFORNIA

An Adolescent Provider Toolkit



**HOW TO OBTAIN A COPY
OF THIS TOOLKIT**

This toolkit can be downloaded from the following websites:
Adolescent Health Working Group - www.ahwg.net
San Francisco Health Plan – www.sfhp.org

Additional copies of the Toolkit may be requested via mail, telephone, fax or e-mail from:

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**ADOLESCENT HEALTH
WORKING GROUP**

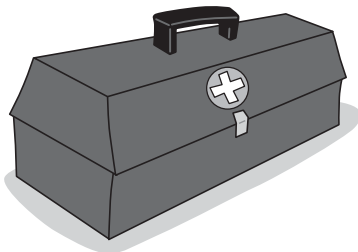
The Adolescent Health Working Group (AHWG) was formed in 1996 when adolescent health providers, administrators, and youth advocates in San Francisco became concerned about Medicaid managed care's impact on young people's access to youth-sensitive, comprehensive health care. Today, the mission of the AHWG is to significantly advance the health and well-being of San Francisco's youth by applying the collective wisdom, resources, and energy of individuals and agencies that care for and support young people. The AHWG's activities include conducting community research, public policy advocacy, and training activities. Members of the collaborative include representatives of youth development agencies; public and private primary care, behavioral health clinics and programs; academic institutions; health plans; schools; social service and advocacy organizations; youth and parents.

SAN FRANCISCO HEALTH PLAN

San Francisco Health Plan (SFHP) is a licensed community health plan providing affordable health coverage to low and moderate-income families residing in San Francisco. SFHP was designed for and by the residents it serves, many of whom would not be able to otherwise obtain health care for themselves or their families. Through SFHP, members have access to a full spectrum of medical services, including preventive care, hospitalization, prescription drugs, family planning, and substance abuse programs. SFHP's mission is to provide superior, affordable health care that emphasizes prevention and promotes healthy living, with the goal of improving the quality of life for the people of San Francisco.

SUGGESTED CITATION

M. Simmons, J. Shalwitz, S. Pollock, A. Young (2003). *Understanding Confidentiality and Minor Consent in California: An Adolescent Provider Toolkit. First Revised Edition*. San Francisco, CA: Adolescent Health Working Group, San Francisco Health Plan.





San Francisco Health Plan
San Francisco, CA



Adolescent Health Working Group
San Francisco, CA

Dear Colleagues:

We are pleased to present you with the first revised edition of *Understanding Confidentiality and Minor Consent in California: An Adolescent Provider Toolkit*. This is one module of a larger project, The Adolescent Provider Toolkit, made possible through the generous support of The California Endowment and our close collaboration with the San Francisco Health Plan (SFHP). The Toolkit contains resources to help health care providers better meet the needs of adolescent patients.

Adolescents list concerns about confidentiality as the number one reason they might forgo medical care. A young person is more likely to disclose sensitive information if he or she is provided with confidential services and has time alone with the provider. However, providers indicate that they are mystified and confused by the various confidentiality and minor consent laws and about their reporting responsibilities. This toolkit, compiled by a multi-disciplinary group of lawyers, health care providers, and youth advocates, strives to clarify these issues.

Designed for busy providers, the Toolkit includes materials that you are free to copy and distribute to your adolescent patients and their families or to hang in waiting and exam rooms. In addition, you can access our online confidentiality training through our website, without charge..

If you have questions regarding the Toolkit or its accompanying trainings and resources, please call the Adolescent Health Working Group at (415) 576-1170.

Regards,

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ACKNOWLEDGEMENTS

The Adolescent Health Working Group gratefully acknowledges The California Endowment for generously supporting the production of this toolkit.

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We would like to extend our sincerest thanks to members of the Toolkit Advisory Council for their time, energy, dedication and unwavering commitment to the health of adolescents.

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We would also like to thank the following individuals and organizations for contributions of their experience, ideas, and tools.

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Renee Cheney-Cohen – Child Health and Disability Prevention Program
Natalie Combs
Abigail English, JD- Center for Adolescent Health and the Law
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MODULE ONE:

Confidentiality

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* Please copy and distribute these handouts to teens and their caregivers.
Spanish and Chinese versions are available online at www.ahwg.net or
www.sfhp.net or by calling 415-576-1170.



CALIFORNIA MINOR CONSENT LAWS:

Which minors can consent for what services and providers' confidentiality obligations

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
<p>PREGNANCY</p>	<p>“A minor may consent to medical care related to the prevention or treatment of pregnancy,” except sterilization. (Cal. Family Code § 6925).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).</p>
<p>CONTRACEPTION</p>	<p>A minor may receive birth control without parental consent. (Cal. Family Code § 6925).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).</p>
<p>ABORTION</p>	<p>A minor may consent to an abortion without parental consent and without court permission. (American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (1997)).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).</p>
<p>EMERGENCY MEDICAL SERVICES*</p> <p>*An emergency is “a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death” (Cal. Code Bus. & Prof. 2397 (c)(2)).</p>	<p>A minor who has a condition or injury which is considered an emergency but whose parent or guardian is unavailable to give consent is permitted to give consent for medical services. (Cal. Bus. and Prof. Code § 2397).</p>	<p>The health care provider shall inform the minor’s parent or guardian. (Cal. Bus. and Prof. Code § 2397).</p>
<p>SEXUAL ASSAULT*</p> <p>SERVICES</p> <p>* For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other violent crimes of a sexual nature.</p>	<p>A minor who may have been sexually assaulted may consent to medical care related to the diagnosis, treatment and the collection of medical evidence related to the assault. (Cal. Family Code § 6928).</p>	<p>The health care provider must attempt to contact the minor’s parent/guardian and note in the minor’s record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928).</p>
<p>RAPE* SERVICES FOR MINORS UNDER 12 YRS**</p> <p>*Rape requires an act of non-consensual sexual intercourse.</p> <p>** See also “Rape Services for Minors 12 and Over” in this table.</p>	<p>A minor under 12 years of age who may have been raped may consent to medical care related to the diagnosis, treatment and the collection of medical evidence related to the rape. (Cal. Family Code § 6928).</p>	<p>The health care provider must attempt to contact the minor’s parent/guardian and must note in the minor’s record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the rape or assault. (Cal. Family Code § 6928).</p>
<p>*SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT</p> <p>* The provider does not need the minor’s or her parent’s consent to perform a procedure under this section.</p>	<p>“A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child’s parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of.” (Cal Penal Code § 11171).</p>	<p>Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.</p>

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
<p align="center">OUTPATIENT MENTAL HEALTH SERVICES*</p> <p>* This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.</p>	<p>“A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services; (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.” (Cal. Family Code § 6924).</p>	<p><u>MENTAL HEALTH TREATMENT:</u> The health care provider is required to involve a parent or guardian unless the health care provider decides that involvement is inappropriate. This decision must be documented in the minor’s record.</p> <p><u>SHELTER:</u> Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services. (Note: The parent/guardian of a minor shall not be entitled to inspect or obtain copies of the minor’s patient records where the health care provider determines that access to the patient records requested by the parent/guardian would have a detrimental effect on the provider’s professional relationship with the minor patient or the minor’s physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor’s records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith. (Cal. Health & Safety Code § 123115(a)(2)).</p>
<p align="center">DIAGNOSIS AND/OR TREATMENT FOR INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES</p>	<p>“A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease... is one that is required by law...to be reported...” (Cal. Family Code § 6926).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).</p>
<p align="center">DIAGNOSIS AND/OR TREATMENT FOR SEXUALLY TRANSMITTED DISEASES</p>	<p>A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the diagnosis or treatment of the disease. (Cal. Family Code § 6926).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).</p>

MINORS 12 YEARS OF AGE AND OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
<p>AIDS/HIV TESTING AND TREATMENT</p>	<p>A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020). A minor 12 and older may consent to the diagnosis and treatment of HIV/AIDS. (Cal. Family Code § 6926).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).</p>
<p>DRUG AND ALCOHOL ABUSE TREATMENT*</p> <ul style="list-style-type: none"> This section does not authorize a minor to receive replacement narcotic abuse treatment without the consent of the minor's parent or guardian. This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. (Cal. Family Code § 6929(f)). 	<p>“A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem.”(Cal. Family Code §6929(b)).</p>	<p>There are different confidentiality rules under federal and state law. Providers meeting the criteria listed under 'federal' below must follow the federal rule. Providers that don't meet these criteria follow state law.</p> <p>FEDERAL: Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria:</p> <ol style="list-style-type: none"> The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.)(42 C.F.R. §2.12); AND The individual or program: <ol style="list-style-type: none"> Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; OR Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; OR Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. (42 C.F.R. §2.11; 42 C.F.R. §2.12). <p>For individuals or programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor's written consent. One exception, however, is that an individual or program may share with parents if the individual or program director determines the following three conditions are met: (1) that the minor's situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor's parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. (42 C.F.R. §2.14).</p> <p>STATE: For programs that don't meet the above criteria, state law applies. State law allows health care providers to determine whether involving a parent or guardian in the minor's treatment would be appropriate. This decision must be documented in the minor's record. (Cal. Family Code §6929(c)). A provider shall not be liable for any good faith decisions concerning access to a minor's records. (Cal. H & S Code §123115(a)(2)).</p>

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
RAPE SERVICES FOR MINORS 12 AND OVER	“A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.” (Cal. Family Code 6927).	The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).
MINORS MUST BE 15 YEARS OF AGE OR OLDER	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
GENERAL MEDICAL CARE	“A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence. (3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.” (Cal. Family Code § 6922(a)).	“A physician and surgeon or dentist MAY, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.” (Cal. Family Code § 6922(c)).
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
GENERAL MEDICAL CARE	An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). “A person under the age of 18 years is an emancipated minor if any of the following conditions is satisfied: (a) The person has entered into a valid marriage, whether or not the marriage has been dissolved. (b) The person is on active duty with the armed forces of the United States. (c) The person has received a declaration of emancipation” from the court. (Cal. Family Code § 7002).	The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical records with the signed consent of the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. 56.10, 56.11).

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WHEN MANDATED REPORTERS IN CALIFORNIA MUST REPORT CONSENSUAL DISPARATE AGE SEXUAL ACTIVITY TO CHILD ABUSE AUTHORITIES

1 If a minor has consensual sexual intercourse with an older (or younger) partner, is a report mandated?*

AGE OF PARTNER ►	12	13	14	15	16	17	18	19	20	21	21+
AGE OF PATIENT ▼											
11	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
12	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
14	Y	Y	N	N	N	N	N	N	N	Y	Y
15	Y	Y	N	N	N	N	N	N	N	Y	Y
16	Y	Y	N	N	N	N	N	N	N	N	N
17	Y	Y	N	N	N	N	N	N	N	N	N
18	Y	Y	N	N	N	N	N	N	N	N	N

Chart by David Knopf, LCSW, UCSF. Adapted from Knopf, “When Am I Mandated to Report the Sexual Activity of Minors to Children’s Protective Services or Police in California.”

2 If a minor engages in consensual sexual activity that is not sexual intercourse with an older or younger partner, is a report required?*

Mandated reporters must report sexual activity (“lewd and lascivious acts”) when a minor is 14 or 15 and the partner is 10 or more years older, (14 year old with an adult 24 years or older/ 15 year old with an adult 25 years or older), or when a minor is under 14 and the partner is 14 or older, regardless of claimed consent by the minor.

3 What other sexual activity must be reported by a mandated reporter? **

Mandated reporters must report sexual intercourse or other sexual activity with a minor under 18 years old when the activity appears coerced, exploitative, based on intimidation, or in any other way resembles abuse -- regardless of claimed consent by the minor and regardless of partner age.

* The law does not require providers to ask about partner age.

**This worksheet is not intended to be a complete review of all California child abuse reporting laws.

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Chart available at www.youthlaw.org.



CONFIDENTIALITY AND MINOR CONSENT Q&A

<p>Q: What are the services a minor can consent to?</p>	<p>A: See Chart A-1 “CALIFORNIA MINOR CONSENT LAWS: Who can consent for what services and providers’ obligations.”</p>
<p>Q: If a minor cannot give consent to health care, who (besides a parent) can give it for them?</p>	<p>A: Adult Caretaker: With letter from parent, or with caregiver consent affidavit Guardian: With court order granting guardianship Court: Minors 16 and over whose parents are unavailable Juvenile court: Minor who is a dependent of court Foster Parent: Only with dependency court permission Emergency: Consent not required in an emergency</p>
<p>Q: How far should I go when trying to reach a parent?</p>	<p>A: When parental consent is necessary in order to provide a service, the provider must obtain that consent. If the provider is unable to reach a parent and believes that treatment must be provided immediately, the provider should proceed if the youth’s medical condition qualifies as an emergency. The provider should clearly document his/her actions and decisions and rationale for treatment or interventions.</p>
<p>Q: Can consent be given verbally?</p>	<p>A: California statutes do not specifically require that consent be written. Often, for routine uncomplicated care, providers feel comfortable with verbal consent. In these cases, it is clear that the person giving consent understands the risks and consequences of the procedure and that the verbal communication is documented in the medical record. If the treatment is more complicated, the provider may want a signed consent form to be sure that the person providing consent is providing “informed consent” and understands the ramifications of the procedures performed. Health care providers should establish an office policy to provide all staff guidance.</p>
<p>Q: If parents give consent to treatment, does that give them the right to look over medical records?</p>	<p>A: The general rule is that parents have a right to see medical records if the parents consented to the treatment. HOWEVER, California law gives health care providers the right to refuse access to records anytime the health care provider determines that access to the patient records would have a detrimental effect on the provider’s professional relationship with the minor patient or the minor’s physical or psychological well-being. (Cal. Health and Safety Code § 123115(a)(2)). The health care provider is not liable for denying access to records under this provision if the decision to deny access was made in good faith.</p>
<p>Q: When the youth has the right to confidential care, what do I do if I’m uncomfortable NOT telling parents?</p>	<p>A: If a minor has the legal right to confidential care, a provider must abide by that right or risk liability or other legal sanction. There are a few minor consent statutes that grant the health provider the right to decide whether contacting a parent is appropriate or necessary even over the minor’s objection. One example is the minor consent drug treatment statute. See the Chart A-1 confidentiality column for statutes that allow providers to share with parents over the minor’s objection. In those cases and no others, a provider can rely on their professional judgment to decide whether to share information with parents.</p> <p>Providers are not legally obligated to provide services to which they are morally or ethically opposed. In such circumstances, the provider should refer the adolescent to another provider, clinic, or program who can better meet the teen’s health care needs.</p>



CONFIDENTIALITY AND MINOR CONSENT Q&A

Q: What if the minor does not SEEM competent to make his or her own decisions? (low IQ, drug use, adult influence)

A: A patient is competent if the patient (1) understands the nature and consequence of his/her medical condition and the proposed treatment and (2) can communicate his/her decision.

Providers can make their own assessment of a patient's competency and do not need a judicial ruling or psychiatric diagnosis in order to find a patient incompetent. When assessing whether the patient understands the nature and consequences of his/her medical condition (and can communicate his/her decision) take into account the following:

- (1) Always start with the presumption that a patient is competent.
- (2) Minority age alone is not a sufficient basis for determining if someone is incompetent. The law specifically deems minors capable of providing consent in certain medical situations.
- (3) Physical or mental disorders alone are not a sufficient basis for finding incompetency.
- (4) The nature and consequence of the medical condition must be explained in terms a minor would understand.
- (5) Believing that the patient is making an unwise or "wrong" medical decision is not a sufficient basis for finding the patient incompetent.
- (6) Competency is situation specific. A minor deemed incompetent in one situation may not be considered incompetent in all situations.

Q: How can we provide confidential care when the patient's health plan sends Explanation of Benefits (EOBS), bills, or surveys home after a visit?

A: If you know that a health plan will automatically send out materials to your patient you can do the following:

- (1) Become a Family PACT provider and bill for services through this program.
- (2) Urge your patient to sign-up for the MediCal Minor Consent program and bill for services through this program.
- (3) Refer your patients to Family PACT or MediCal Minor Consent providers. See Chart A-7, "Financing Tips for Providing Confidential Teen Services"
- (5) Contact the patient's health plan and let them know your concerns.

Q: I know that minors over 12 can consent to their own mental health care when they are mature enough to participate in the service and the minor would present "a danger or serious physical or mental harm to self or others without the mental health treatment." But, what is "serious harm?"

A: There is no statute or regulation that defines the term "serious harm". The interpretation of this term is left to the discretion and professional judgment of the provider. We recommend that you develop guidelines for your staff to ensure consistency in your office/clinic/agency. The San Francisco Department of Public Health (SFDPH) policy uses the Global Assessment of Functioning (GAF) scale to assess psychological and social functioning. According to SFDPH, a score of <60 indicates symptoms and level of functioning that satisfies the definition of "serious danger of physical or mental health harm." (Lubosky, L. "Clinicians' Judgments of Mental Health," Archives of General Psychiatry, 7: 407-417, 1962)



MANDATED REPORTING Q&A

Q: Who is a Mandated Reporter?

A: There is a list of 33 mandated reporters, but those pertaining to adolescent health services are:
 1) Physicians 2) Surgeons 3) Psychiatrists 4) Psychologists 5) Psychological Assistants 6) Mental Health and Counseling Professionals 7) Dentists 8) Dental Hygienists 9) Registered Dental Assistants 10) Residents 11) Interns 12) Podiatrists 13) Chiropractors 14) Licensed Nurses 15) Optometrists 16) Marriage, Family and Child Counselors, Interns and Trainees 17) State and County Public Health Employees 18) Clinical Social Workers 19) EMT's and Paramedics 20) Pharmacists

Q: Why and when am I required to make a report?

A: The California Child Abuse and Neglect Reporting Act created a set of state statutes that establish the whys, whens and wheres of reporting child abuse in California.

“Mandated reporters” are required to make a child abuse report anytime, in the scope of performing their professional duties, they discover facts that lead them to know or reasonably suspect a child is a victim of abuse.

Reasonable suspicion of abuse occurs when “it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse or neglect.”

The Act requires professionals to use their training and experience to evaluate the situation; however, “nothing in the Act requires professionals such as health practitioners to obtain information they would not ordinarily obtain in the course of providing care or treatment. Thus, the duty to report must be premised on information obtained by the health practitioner in the ordinary course of providing care and treatment according to standards prevailing in the medical profession.” (People v. Stockton Pregnancy Control Medical Clinic, 203 Cal.App.3d 225, 239-240, 1988)

The pregnancy of a minor in and of itself does not constitute a basis for a reasonable suspicion of sexual abuse. A child who is not receiving medical treatment for religious reasons shall not be considered neglected for that reason alone.

Q: What about the right of patient confidentiality?

A: Child Abuse reporting is one of the few exceptions to patient confidentiality. Reporters do not need the minor or parent’s consent to share the otherwise confidential information necessary to make a report. The Child Abuse Reporting Act specifically exempts reporters from any liability if they make a good faith report of abuse.

Q: When does a mandated reporter have to report sexual activity?

A: See Chart A-2 “When am I Mandated To Report The Sexual Activity of Minors to Children’s Protective Services or Police in California?”



MANDATED REPORTING Q&A

Q: How do I make a report?

A:

1. First, call the California Department of Social Services immediately (in Sacramento, 916-445-6951). If you are unsure whether you need to report, call this number. You may also go to the DSS website at www.dss.cahwnet.gov/cdssweb/ for more information. You must report the abuse to the county in which the young person lives. If the place of residence and place of abuse are not the same, you must report in both counties. Let the reporter know this information at the beginning of your report.
2. You must file a written report (DOJ form SS 8572) within 36 hours of the verbal report. See an example of the report form on the back of this page.

Q: What will I report?

A:

1. Your name, although this is kept confidential except in certain, limited, situations.
2. The child's name
3. The present location of the child
4. The nature and extent of the injury
5. Any other information, including that which led you to suspect child abuse, requested by the child protective agency
6. If the child does not feel safe returning to the place of abuse or if he or she is in immediate danger, report this information as well.

Q: What happens to the reports?

A:

1. The report will be investigated either by the local law enforcement agency or by the child protective services agency.
2. The report will be assessed as to whether there is a need for immediate action.
3. High risk factors will be considered to determine whether immediate face-to-face contact is required (ex. Direct interviews with anyone who might provide more information on the situation.)
4. The report will be determined to be either
 - a. Unfounded (false, inherently improbable, to involve accidental injury, or not to constitute child abuse)
 - b. Substantiated (constitutes child abuse or neglect)
 - c. Inconclusive (not unfounded, but the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect has occurred)

Q: What happens if the report is not unfounded?

A:

1. It will be forwarded to the Child Abuse Central Index and investigation will continue.
2. The child may be taken into protective custody.
3. The case can be officially opened and regular in-home supervision and a number of services are provided.

Q: Will I be told about the status of the report?

A: The Child Protective Agency is required to provide mandated reporters with feedback about the report and investigation. It might be necessary to be proactive in this situation by calling the Department of Social Services.

Q: Is there a statute of limitations?

A: No. If an individual under 18 years old tells you about abuse, even if it occurred when he or she was a young child, you must report it. Other agencies will decide whether the case should be pursued.



SUSPECTED CHILD ABUSE REPORT

To Be Completed by Reporting Party
Pursuant to Penal Code Section 11166

A. CASE IDENTIFICATION	TO BE COMPLETED BY INVESTIGATING CPA
	VICTIM NAME: _____
	REPORT NO./CASE NAME: _____
DATE OF REPORT: _____	

B. REPORTING PARTY	NAME/TITLE						
	ADDRESS						
	PHONE ()		DATE OF REPORT		SIGNATURE		
C. REPORT SENT TO	<input type="checkbox"/> POLICE DEPARTMENT <input type="checkbox"/> SHERIFF'S OFFICE <input type="checkbox"/> COUNTY WELFARE <input type="checkbox"/> COUNTY PROBATION						
	AGENCY			ADDRESS			
	OFFICIAL CONTACTED			PHONE ()		DATE/TIME	
D. INVOLVED PARTIES	VICTIM	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE	SEX	RACE
		PRESENT LOCATION OF CHILD			PHONE ()		
	SIBLINGS	NAME	BIRTHDATE	SEX	BIRTHDATE	SEX	RACE
		1. _____					
		2. _____					
	PARENTS	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE	SEX	RACE
		ADDRESS			ADDRESS		
HOME PHONE ()		HOME PHONE ()		BUSINESS PHONE ()			
IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS BOX. <input type="checkbox"/>							
E. INCIDENT INFORMATION	1. DATE/TIME OF INCIDENT		PLACE OF INCIDENT (CHECK ONE)		<input type="checkbox"/> OCCURRED <input type="checkbox"/> OBSERVED		
	IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:						
	<input type="checkbox"/> FAMILY DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> SMALL FAMILY HOME <input type="checkbox"/> GROUP HOME OR INSTITUTION						
	2. TYPE OF ABUSE: (CHECK ONE OR MORE)						
	<input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL ASSAULT <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER						
3. NARRATIVE DESCRIPTION:							
4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED:							
5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD:							

THIS IS AN EXAMPLE ONLY
OBTAIN COPIES FROM THE
DEPARTMENT OF SOCIAL SERVICES

SS 8572 (Rev. 1/93)

INSTRUCTIONS AND DISTRIBUTION ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). A CPA is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS-8583 if (1) an active investigation has been conducted and (2) the incident is **not** unfounded.

Police or Sheriff-WHITE Copy; County Welfare or Probation-BLUE Copy; District Attorney-GREEN Copy; Reporting Party-YELLOW Copy

Sources:

The Office of the Attorney General, Child Abuse Prevention Handbook, http://caag.state.ca.us/cvpc/main_pub_videos.html

Health Initiatives for Youth, Adolescent Provider's Guide, 1998.

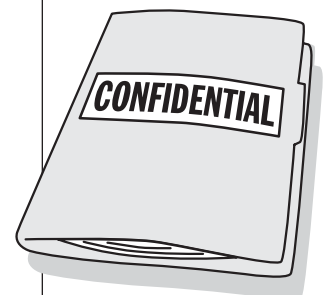
San Francisco Child Abuse Council, A Training Curriculum for Mandated Reporters on the California Child Abuse Reporting Law, 1995.



IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS?

Adolescents tend to underutilize existing health care resources. *The issue of confidentiality has been identified by both providers and youth as a significant access barrier to health care.* To support the promotion of adolescent care, please take a few moments to assess your office in determining whether it is confidentiality conscious. Creating a safe environment for teenagers to discuss issues concerning their health will facilitate the best possible care and counseling to respond to their needs.

- Do you have an office policy about confidential issues pertaining to youth and their families?
- Is it the usual practice in your clinic to allow adolescents and parents to talk separately with the health care providers about their concerns?
- Do you educate your members and staff regarding the California laws that specifically pertain to adolescents and their right to receive care without their parent or guardian's consent? (Please see "Summary of Legal Consent Requirements for Medical Treatment of Minors", included in this packet.)
- Does the atmosphere (pictures, wallpapers, etc.) create a safe and comfortable environment for teens to discuss private concerns regarding their health?
- Do you display and/or offer educational materials on confidentiality to adolescent patients and/or parents?
- Are you and your staff careful not to discuss patient information in open environments (elevators, hallways or waiting rooms)?
- When collecting an adolescent patient's medical history or discussing anything sensitive, do you make sure all doors are closed?
- Do you ask if your adolescent patient feels comfortable receiving messages or mail from you using the contact information they provide?
- At the beginning of the appointment, do you explain the parameters of confidentiality between you, your patients, and his/her parents?
- Do you discuss situations in which you may need to breach confidentiality?



TIPS FOR PROTECTING YOUTH CONFIDENTIALITY

While adolescent confidentiality laws provide us with formal (although often confusing) guidelines for ensuring confidentiality of our teen patients, it is frequently the small stuff that can seriously compromise an adolescent patient’s confidence in his/her provider. The following is a list of tips – some obvious, some not – for preserving patient privacy and minimizing embarrassment in a clinic setting.

1. Do not discuss patient information in elevators, hallways, or waiting rooms.

If an adolescent patient overhears this conversation, he or she may assume that you will also discuss his or her case in an open environment.

2. Do not collect an adolescent patient’s medical history or reason for visit in an open area.

It will be difficult for a teenager to discuss his or her personal issues honestly if s/he thinks other people will overhear.

3. When an adolescent patient gives you a contact phone number, make sure that you can leave messages.

If you cannot, ask for an alternative number at which you can leave messages if necessary.

4. Likewise, do not send mail (such as appointment reminders and bills) home unless you have discussed whether or not the patient feels comfortable receiving mail from you at his or her home.

If he or she does not wish to receive mail at home, try to work out an arrangement whereby mail is picked up at the clinic. TIP: Some clinics have check boxes on charting forms indicating a teen’s preference regarding mail and phone calls. Other clinics clarify what kind of message might be ok to leave at a teen’s contact number (e.g. “Tina” called).

5. When discussing anything sensitive, such as sexual history, weight, or substance use, make sure all doors are closed.

A patient in the waiting room may overhear a discussion and thus be more reluctant to share information when he or she sees the health care provider.

6. Think about how your clinic administers paperwork to patients.

Are you asking clients to fill out forms such that other people might be able to read their answers? Give out a clipboard with the forms; also make sure that there is enough room in which to complete forms with some degree of privacy.

7. Make sure that any clinic literature your clinic or practice distributes is small enough to fit into a purse or wallet.

Asking a teenager to leave with bright, large brochures on a sensitive subject, such as gonorrhea, will cause more embarrassment than anything else. These types of materials should be offered to teens in private.

8. At the beginning of the appointment, make it clear that a provider is required to maintain patient confidentiality, except under very specific circumstances.

Periodically remind the patient that anything s/he says about sex, drugs, and feelings will not leave the room.



PERFORMING AN ATRAUMATIC “PARENTECTOMY”

Or, how do I provide adolescent-sensitive services when a parent or caregiver is present?

Attempting to provide confidential services can cause great discomfort for youth, parents, and providers if it is not handled in a sensitive manner. The following are recommendations that can facilitate a smooth transition from the parent-accompanied visit to the confidential adolescent visit.

ROADMAP

- Lay out the course of the visit...

for example, “We will spend some time talking together about Joseph’s health history and any concerns that you or he might have, and then I will also spend some time alone with Joseph. At the end of the visit, we will all meet together again to clarify any tests, treatments or follow-up plans.”

- Explain your office/clinic policy regarding adolescent visits.

Review your policy verbally early in the interaction with the youth and parent.

Acknowledge that the youth is a minor and therefore has specific legal rights related to consent and confidentiality.

Introduce the concept of fostering adolescent self-responsibility and self-reliance.

Reinforce that this policy applies to all adolescents in your practice or clinic (in other words, this is not specific to YOUR child).

- Validate the parental role in their child’s health and well-being.
- Elicit any specific questions or concerns from the parent.
- Direct questions and discussion to the youth while attending to and validating parental input.

REMOVE

- Invite the parents to have a seat in the waiting area, assuring them that you will call them prior to closing the visit

REVISIT

- Once the parent is out of the room, revisit issues of consent and confidentiality with the youth, including situations when confidentiality has to be breached (suicidality, abuse, etc.).
- Revisit areas of parental concern with the youth and obtain the youth’s perspective.
- Conduct the psycho-social interview and physical exam (ascertain whether youth desires parent’s presence during PE and accommodate youth’s preference).
- Clarify what information from the psycho-social interview and PE the youth is comfortable sharing with parent.

REUNITE

- Invite the parent back to close the visit with both parent and youth.

TIPS...

- A young person is more likely to disclose sensitive information to a health care provider if the youth is provided with confidential services, and has time alone with the provider to discuss his/her issues.
- Remember that even when the chief complaint is acne or an ear-ache, there may be an underlying issues on the part of the adolescent (such as the need for a pregnancy test or contraception), which will only surface when provided confidential services.

EXTRA NOTES:

Additional ways to explain your policy regarding confidentiality:

- A letter to all new adolescent patients and their parents, and all parents and patients on the youth’s 11th or 12th birthday explaining your policy. This will help families to come prepared for the adolescent and the provider to spend some time alone.
- Posters in the waiting area explaining adolescent consent and confidentiality and your policy as it relates to the law can also help lay groundwork that the provider will be spending time alone with the youth.



FINANCING SENSITIVE SERVICES: A GUIDE FOR ADOLESCENT HEALTH CARE PROVIDERS

Payment for sensitive services (i.e. STD testing and treatment, pregnancy tests, substance use counseling) can pose an enormous barrier to youth seeking confidential health care. Young people may not have enough money to pay for the services that they need. Often, they are also worried that if they access a free or low cost program such as Family PACT (Planning, Access, Care, and Treatment) or Medi-Cal, their confidentiality will be compromised. It is thus important to understand the laws and policies governing the ways in which young people can access free or low cost sensitive services.

California State has two programs that reimburse confidential health services for youth: Medi-Cal Minor Consent and Family PACT. Below you will find information on how to become a provider in each of these programs, how to determine youth eligibility, and how to receive payment for services rendered.



	MEDI-CAL MINOR CONSENT	FAMILY PACT
SERVICES COVERED	<ul style="list-style-type: none"> • Pregnancy and pregnancy-related services, including abortion • Family planning (birth control), including emergency contraception • Drug and alcohol counseling and treatment • Sexually transmitted diseases testing and treatment • Sexual assault treatment 	<ul style="list-style-type: none"> • Pregnancy testing, counseling, and referral • Family planning methods, including birth control and emergency contraception • Sexually transmitted diseases testing and treatment • Education and counseling about reproductive health • HIV testing and counseling • Referrals for other services
CLIENT ELIGIBILITY (Age)	12 up to 21	Females, 55 and under. Males, 60 and under.
CLIENT ELIGIBILITY (Income)	Any income	200% of federal poverty level and below.
CLIENT ELIGIBILITY (Citizenship)	Client must be a California resident	Client must be a California resident.
INFORMATION REQUESTED FROM CLIENT	First name, phone number, address to which confidential mail can be sent; Social Security Number is NOT requested.	Enrollment is by client report. Social Security Number is NOT required.

(Continued on next page)

	MEDI-CAL MINOR CONSENT	FAMILY PACT
CLIENT CO-PAY	None	None
HOW A YOUNG PERSON CAN UTILIZE THIS PROGRAM	Call or visit your county Social Services office. A list of local Social Services is available at www.dhs.ca.gov/mcs/medi-calhome/countylisting1.htm	Client must visit a Family PACT provider, who will enroll the youth in the program. Services can be accessed immediately.
FOR MORE INFORMATION	Contact the Medi-Cal provider support center.	Contact the California Office of Family Planning at (916) 654-0357.
HOW CAN A CLINIC BECOME A PROVIDER	Provider must be a Medi-Cal provider. Call EDS at 1-800-541-5555 or visit http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/prov_enroll.asp to download provider application forms.	Call the Family PACT Hotline at 1-800-257-6900 or visit Family PACT Provider Support Services at http://www.familypact.org . Providers must attend a one-day orientation program.

KEY DIFFERENCES BETWEEN MEDI-CAL MINOR CONSENT AND FAMILY PACT:

1. While both programs cover pregnancy testing, Family PACT does not cover abortion or care once one is pregnant. Medi-Cal Minor Consent does.
2. Family PACT covers individuals 55 and under for females and 60 and under for males; Medi-Cal Minor Consent covers up to age 21.
3. Clients must enroll in Family PACT at a FPACT provider’s office. With Medi-Cal Minor Consent, however, clients enroll with an eligibility worker.
4. For Family PACT, eligible clients are activated for one year following application and reconfirmed at each date of service; for Medi-Cal Minor Consent, clients must renew eligibility every 30 days.



TIPS FOR TEENS

The Truth About CONFIDENTIALITY...

Confidentiality means privacy. It means that when you, as a young person from 12 to 17 years old, talk with your health care provider about certain issues like sex, drugs, and feelings, he or she will not tell your parents or guardians what you talk about unless you give your permission.

What should I talk to the doctor or nurse about?

You can talk to your doctor or nurse about ANYTHING! Fill your doctor or nurse in if you...

- think you might be **pregnant**.
- need **birth control**.
- think you have a **sexually transmitted disease (STD)**.
- need information about **alcohol, tobacco, or other drug use**.
- want to talk about **personal, school, family issues, or feelings about sex and sexuality**.

What will my doctor or nurse tell my parents?

According to the laws of the State of California, your doctor or nurse cannot tell your parents or guardians anything about your exam if you're seen for any **confidential** services. These include care for problems or concerns in the areas of sexuality, mental health and substance abuse. You, as a young person, **can consent** for care on your own in these areas. You need your parent or guardian's consent for other health services such as physicals and care for colds, flu, and injuries.

HOWEVER...

Some things cannot remain confidential. Your health care provider will need to contact someone else to help if you say...

- you are being **abused, physically and/or sexually**.
- you are going to **hurt yourself or someone else**.
- you are under 16 and **having sex with someone 21 years or older**.
- you are under 14 and **having sex with someone 14 years or older**.

Even though you don't have to ask your parents, it's a good idea to talk with them or another adult you trust about the medical care you need. We want you to be safe. If you have any questions about confidentiality, please ask us!



A LETTER FROM YOUR TEEN'S HEALTH CARE PROVIDER

Dear Parent or Guardian,

Now that your son or daughter is a teenager, there are some things I would like to share with you that are important to provide the best care. Your son or daughter's body is changing, and so are his or her feelings. There are many health risks during the teenage years that we try to prevent, such as accidents, violence, unprotected sex, alcohol and drug use, and stress.

Some areas of teen health that we may talk about during the appointment are:

- Diet, exercise, and body image
- Fighting, danger, and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs, and alcohol
- Working/Jobs
- Depression and stress
- Peer pressure and school
- Dating and relationships
- Family life

It is good to stay close to your child. It is also important for you to allow them some time alone to talk about their health and changes in their bodies and lives. This will help your teenager make good decisions. I encourage teenagers to share information about their health with their parents or guardians. However, there will be some things that your teenager would rather talk about with a doctor, nurse, or counselor. California law allows teenagers to receive some health care services on their own. Health care providers have to keep those services CONFIDENTIAL. "Confidential" means I will only share this information if a teenager says it's alright. I will also share this information if someone is in danger.

I can contact you about most of the services your child receives. However, if your teenager receives the following services, I cannot give you information about these visits without permission from your son or daughter:

- The prevention or treatment of pregnancy or sexually transmitted diseases (STDs) and other contagious diseases
- The diagnosis and treatment of sexual and physical abuse
- Care and counseling for drug or alcohol problems

I ask that you support these rules and help your teen learn to care for their own health needs. I look forward to providing ongoing medical care for your child. I will be happy to talk to you about the questions or concerns you may have about this letter and your child's health.

CAREGIVER'S AUTHORIZATION AFFIDAVIT

Use of this affidavit is authorized by Part 1.5 (commencing with section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1 - 4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5 - 8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____ .

2. Minor's birth date: _____ .

3. My name (adult giving authorization): _____ .

4. My home address: _____

5. () I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back page of this form for a definition of "qualified relative").

6. Check one or both (for example, if one parent was advised and the other cannot be located):

() I have advised the parent (s) or other person (s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.

() I am unable to contact the parent (s) or other person (s) having legal custody of the minor at this time, to notify them of my intended authorization.

7. My date of birth: _____

8. My California's drivers license or identification card number: _____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

(Notices on following page)

Notices:

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the Caregiver has legal custody of the minor.
2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
3. This affidavit is not valid for more than one year after the date on which it is executed.

Additional Information:To Caregivers:

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.
2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions please contact your local Department of Social Services.
3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.
4. If you do not have the information requested in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials:

1. Section 48204 of the Education Code provides that this affidavit constitutes a sufficient basis for a determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the Caregiver.
2. The school district may require additional reasonable evidence that the Caregiver lives at the address provided in item 4.

To Health Care Providers and Health Service Plans:

1. No person who acts in good faith reliance upon a Caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or action, for such reliance if the applicable portions of the form are completed.
2. This affidavit does not confer dependency for health care coverage purposes.

Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine

Position

The Society for Adolescent Medicine Reaffirms Its Previous Position that Private and Confidential Health Services Are Essential for Adolescents.

In order to implement this policy, the Society for Adolescent Medicine recommends the following:

- Health providers should inform adolescent patients and their parents, if available, about the requirements of confidentiality, including a full explanation of what confidential care entails and the conditions under which confidentiality might be breached.
- Health providers must remain flexible when delivering confidential care to adolescents. Blind adherence to absolute confidentiality, or absence of confidentiality (in deference to parental wishes), is neither desirable nor required by ethics or law.
- Health providers should develop a disclosure plan for those adolescents who are deemed not to have capacity to give informed consent or for whom disclosure of information to responsible adults becomes necessary which involves adolescent wishes about the manner in which information is shared.
- Confidentiality considerations regarding record keeping are necessary. Health providers must consider the manner in which written and electronic medical records might be available to parties in ways that verbal communication are not, and in ways that would be objectionable to adolescent patients.
- Expanded efforts are needed to increase the education of health professionals regarding the laws and regulations in their jurisdiction relating to confidentiality and informed consent for adolescents. In addition, specific training is needed to increase providers' skills in effectively and appropriately incorporating confidentiality into clinical practice.
- Further research is necessary to evaluate the process of maintaining confidentiality. These investigations should include studies of the attitudes of adolescents related to confidentiality, specific influences of gender and race/ethnicity, provider and parental attitudes about confidentiality, and the approaches necessary to allow professional practices to optionally meet ethical and legal requirements.

Background

There is a growing need for education of health professionals regarding ethical and legal aspects of consent and confidentiality. Adolescents are engaging in a variety of health risk behaviors that should be known to their health providers (1,2).

In addition, the protection of confidentiality within and beyond the health care setting is becoming more precarious owing to health care reform, computerization of health records, and changes in health care administration (3). Results of studies indicate a lack of consensus among practicing health providers about confidentiality when treating adolescent patients (4-7). A recent survey of primary care physicians in California indicates that physicians do not consistently discuss confidentiality with their adolescent patients and do not distinguish between unconditional and conditional confidentiality (7). Although minors' rights to confidential medical care have expanded over the past 25 years, these legal prerogatives undergo ongoing modification. Many states have passed mandatory parental consent and notification laws, especially related to the termination of pregnancy. As laws change, it becomes more difficult for health professionals to maintain familiarity with current laws determining when adolescents may consent for confidential medical care. It is unclear if providers understand these existing laws and policies regarding minor's consent and confidentiality (8),(9).

This article defines necessary terms and concepts, address reasons for confidentiality in adolescent health care, reviews legal guidelines, and provides suggestions for implementation.

Definitions

Confidentiality in a health care setting is defined as an agreement between patient and provider that information discussed during or after the encounter will not be shared with other parties without the explicit permission of the patient. It is best classified as a rule of biomedical ethics that derives from the moral principle of autonomy and accompanies other rules like promise-keeping, truthfulness and privacy (10).

Privacy means freedom from unsanctioned intrusion. In a health care setting it involves psychological, social and physical components in addition to confidentiality (11).

Informed consent describes the process during which the patient learns the risks and benefits of alternative approaches to management and freely authorizes a course of action proposed by the clinician. Informed consent has both ethical and legal derivations. Although usually bound together in clinical encounters, confidentiality and consent are different. Confidentiality can occur during an encounter whether or not specific informed consent for a treatment or intervention is given. For example, contraceptive options may be confidentially discussed before informed consent is given for any specific choice.

Under specific legal circumstances, adolescents may receive

confidential care and may give informed consent for recommended care (12). If the legal circumstances does not justify a minor's consent to medical treatment, the minor's views and opinions can still be respected by obtaining *assent* (13,14). This is an ethical rather than a legal concept. Seeking the assent of a minor who is not legally authorized to consent demonstrates respect for the decision-making skills of a non-autonomous individual to the extent that he/she is able to participate in the decision. This is particularly relevant for adolescents who are cognitively maturing, but below the age of legal majority and still dependent upon adults for their basic health care decisions. Respect for the decision-making capabilities of an adolescent demands both confidentiality and privacy.

Reasons for Confidentiality

The Needs of Clinical Practice

The most practical reason for clinicians to grant confidentiality to adolescent patients is to facilitate accurate diagnosis and appropriate treatment. Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent patient alone, and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to care since the adolescent may withhold information, delay entry into care, or refuse care.

A growing body of research has examined whether minors would seek health care if it were not confidential (15-20). For example, a study of Massachusetts high school students found that 25% would forego health care if confidentiality were not assured (15). In another study, a majority of students reported they would not go to their private physician for care related to sexuality, substance abuse or emotional upset, nor would they seek care for these problems if their parents had to know about the office visit (19). Thus, most adolescents seek confidentiality when questioned about their specific health care needs. (21)

Many other barriers to optimal adolescent health care have been identified, including inadequate health insurance, lack of age-appropriate facilities, office policies, lack of training and sensitivity of physicians and office staff in adolescent issues, and inadequate physician time (22). These barriers limit the opportunity for adolescents to discuss important health and behavioral issues. In a recent California survey, most adolescents reported they were unable to discuss sexual matters with their physicians, despite recognizing the helpfulness of such discussions (23). Confidential care, unlike economic and facility barriers, can be easily addressed, and integrated into clinical practices.

Developmental Needs

Adolescents seek confidentiality for reasons that derive from their unique developmental circumstance. Some teens fear parental retribution (24). Others fear damage to reputation and self-esteem (25). Most adolescents are striving for maturity, independence and adult status. In fact, most individuals over age 14 years have the cognitive ability to process medical

information in a manner similar to adults (26).

The developmental needs and abilities of adolescents as well as the issues under discussion, help shape the physician-patient relationship (27). For example, sexual behavior and orientation, are generally felt to be highly personal matters by both adolescents and adults. Like adults, adolescents seek privacy in discussing these sensitive topics and may worry about parental disapproval. The practitioner and parent can help the adolescent develop independent self-care skills for even the most sensitive of issues by allowing the adolescent to practice confidential self-disclosure to the provider.

The degree to which the confidential relationship contributes to the health of the teenager will depend on each adolescent's developmental, medical, and environmental circumstances. The scope of confidentiality must be flexible and carefully considered. The clinician should take into account the adolescent's developmental capabilities, the presenting problem, and the adolescent's individual needs. By mid-adolescence, most teens are able to reason like adults, but because of inexperience, may require more guidance in medical decision-making. Previous research has found developmental differences between younger and older adolescents in understanding confidentiality and whether the explicit discussion of confidentiality facilitates disclosure of personal information (28,29). For the younger adolescent, the process of building a trusting relationship and demonstrating that confidentiality will be preserved was found to be as important as what was said. Moreover, Messenger and McGuire (28) conclude that a real life experience with this process is superior to a verbal explanation. Gender differences have also been demonstrated (9,28,29). For example, males were found to be more open to disclosure and less concerned about confidentiality violations than females. Studies have demonstrated that adolescents of either gender view confidentiality differently depending upon the health care setting (e.g., family planning or public health clinic), where they expect confidentiality, as compared to private physician's offices, where they are less sure if they will be afforded this practice (15,19).

Moral and Ethical Requirements

Providing confidential care to adolescents is a professional duty deriving from the moral tradition of physicians and the goals of medicine. The first references to the principle of medical confidentiality are found in the codes of professional ethics (30). The fundamental statement on confidentiality in the Western tradition is embodied in the Hippocratic Oath, which influenced all subsequent medical ethical reflections on this matter (31). Two philosophical arguments have been advanced which justify the principle of medical confidentiality. The utilitarian argument refers to the consequences of behavior and states that because confidentiality encourages patients to fully disclose their symptoms and life circumstances, the clinician's capacity to help them will be enhanced. Confidentiality allows for beneficence, or the moral duty to benefit the patient.

The second philosophical argument is based upon the moral-

ity of the action itself distinguished from its anticipated consequences. In this case, confidentiality concerns basic respect for adolescent patients as persons, respect for their autonomy and recognition of their right to privacy. Only recently have these principles been applied to the medical care of teenagers (32). This has created a dilemma for professionals who must balance their interest in protecting the health of their adolescent patients by providing appropriate, timely, confidential care and the desires of parents to know about the condition of their minor children and make decisions regarding their care.

Because adolescents vary in their psychosocial and economic autonomy, it becomes impossible to apply a single moral prescription in all cases. It is necessary to ground confidentiality in the moral necessity of respect for the individual while recognizing that it is permissible to breach confidentiality in selected instances, and only when certain requisites have been fulfilled. Should these special circumstances not be respected because a professional thinks it would be inconvenient or difficult, a clear moral breach will have occurred in which a physician places personal needs above those of the patient. Excessive paternalism results if confidentiality is disregarded because the physician decides what is “best” for the adolescent without a strong and persuasive reason.

Paternalism has been defined as either an interference with a person’s freedom of action (33), as a “refusal to accept or acquiesce in an individual’s choices, wishes and actions,” (34) or as an act of coercion (35). Clinicians need to be extremely cautious when deciding to break confidentiality because it may seriously jeopardize the provider-patient relationship (36). However, in cases of suicidal or homicidal ideation or gestures, serious chemical dependence, the youth’s disclosure of physical or sexual abuse and life threatening medical conditions (i.e., eating disorders), it may be necessary to disclose private information to the adolescent’s caretakers or others. Silber (37) has proposed that “justified paternalism” in the care of adolescents could be appropriate under these circumstances, provided two conditions are met: reasonable evidence that an adolescent’s capacity for autonomy is impaired; and, protecting the adolescent’s life is the central goal. Thus, protecting life outweighs the principle of autonomy.

Should the physician encounter a circumstance in which “justified paternalism” and disclosure better serves the adolescent, there is still a moral duty to respect the adolescent. This can be accomplished by explaining the reason for breaching confidentiality and involving the patient in the process of revealing the confidential information.

Legal Issues and Guidelines

Legal provisions which support confidentiality include, among others, avoiding embarrassment and humiliation, protecting personal and family security, and avoiding discrimination or denial of service (38). For adolescents, legal protection for the maintenance of confidentiality serves two primary purposes. The first purpose (as has been discussed) is clinical utility and encourages them to seek necessary medical care. The second legal purpose is to grant adult rights to those minors who

deserve them by virtue of their maturity. The minor who has achieved a level of maturity sufficient to enable him or her to give informed consent generally is entitled to the associated privacy of information.

The law has evolved in important ways over the past several decades in the degree to which it protects, or at least, does not impede the provision of confidential health services for adolescents. Nevertheless, there continue to be areas in which the current legal system fails to provide adequate protection, particularly with respect to current changes in the health care delivery system, such as the rapid shift to managed care. Moreover, care management will attempt to standardize health care delivery methods and might threaten the unique privacy needs of adolescents in such areas as medical records, care pathways, and gatekeeper functions.

Sources of the Confidentiality Obligation in the Law

There are numerous sources of the general legal obligation to maintain the confidentiality of medical information for adolescents (12,38). These sources include federal and state statutes, constitutional provisions, and regulations, policies, and protocols of federal and state agencies. Many, but not all, of these provisions have been interpreted in court decisions. In particular, the concept of the “mature minor” has been developed by state and federal courts over the past several decades. The concept of the “mature minor” applies to those situations in which an adolescent has the capacity to give an informed consent and is being provided with non-complex care that is within the mainstream of medical practice (39). Thus, the extent to which the law impedes or facilitates the protection of confidentiality in adolescent health care depends not only on the consideration of a broad range of overlapping and interconnected legal provisions, but also on an understanding of how those provisions have been, or might in the future, be interpreted by the courts.

Confidentiality and Consent

The dual concepts of confidentiality and consent are inextricably linked in the way the law affects the delivery of health care to adolescents who are younger than 18 years, the age of majority in almost every state. First, whenever consent for care is required from a parent or other third party, such as a court or child welfare agency, it is not possible for complete confidentiality to be maintained. Second, some laws authorizing minors to consent to their own care also require (or permit) that a parent or another person or entity be informed. Third, some laws governing the confidentiality and disclosure of medical information explicitly rely on the medical consent laws in delineating who controls the confidentiality of health information for minors, and even when they do not, the consent laws may provide implicit support for confidentiality (40).

Generally the law requires the consent of a parent when health care is provided to a minor child, although there are numerous exceptions to this requirement (12). Exceptions include medical emergencies, laws which specifically authorize minors to consent to their own care and care for the “mature minor.” Consent may also be required from a third party such as a legal

guardian or conservator, for a severely mentally incapacitated person who is older than age 18 years.

A legal basis for minors to consent to their own care also provides a strong foundation for assuring that the care may be confidential. Every state has statutes which authorize minors to consent to medical care under a variety of circumstances (41-43). In some statutes, the authorization is based on the minor's status such as when the minor is emancipated, married, serving in the armed forces, pregnant, a parent, or a high school graduate; is living apart from parents; has attained a certain age; or has qualified as a mature minor. In other statutes, the authorization to consent to health care is based on the type of care needed, such as contraceptive services; pregnancy related care; diagnosis and treatment of sexually transmitted disease, human immunodeficiency virus or reportable diseases; treatment for drug or alcohol problems; care related to a sexual assault; or mental health services. These laws reflect policy judgments that certain minors have attained a level of maturity or autonomy which makes it appropriate for them to make their own medical decisions or that adolescents generally are unlikely to seek certain sensitive but essential services unless they are able to do so independent of their parents. While not every state has statutes covering minors in each of the above categories or all types of "sensitive" services, every state has some of these provisions.

Often the laws which authorize minors to consent to their own care also explicitly or implicitly restrict the disclosure of that information without their permission. In addition, other state laws, such as medical confidentiality statutes, sometimes refer back to the minor consent provision, specifying that a minor who has the right to consent also has the right to control the disclosure of confidential information. Finally, the United States Supreme Court, in decisions about the extent to which the constitutional right of privacy protects minors, has made it clear that when a minor is sufficiently mature to give her own consent for an abortion she must also be able to choose to seek an abortion without the knowledge or involvement of her parents, albeit with a judicial order affirming her maturity (44).

Confidentiality and Payment

The relationship between confidentiality and payment for services is a very important consideration. The laws which authorize minors to consent to their own care generally do not make any provision for payment for services, and in some cases, actually relieve parents of financial liability. It may be difficult, even impossible, to assure full confidentiality unless an adolescent has a way to pay for services, or the services are provided without charge.

Generally, parents are financially liable for the health care services provided to their minor children. However, families often rely on private or public health insurance to pay for part or all of the cost of care. Adolescents may be eligible to receive certain services without charge or at an affordable cost in a variety of settings such as community or migrant health centers, school-based and school-linked health clinics, and family planning clinics, among others. Legal provisions applicable to

many of these funding sources do provide some degree of confidentiality protection (43). In some cases, such as federally funded family planning clinics, there are sliding fee scales based on income, and adolescents are permitted to qualify based upon their own income. In the absence of free care or the ability to pay themselves, adolescents may have to rely on direct payment for services by their parents or on utilizing their family's insurance coverage, if any. The necessity for a parent to sign an insurance claim in the case of private insurance, or to furnish a Medicaid card, may dramatically threaten the confidentiality of services. In such circumstances, the informal agreements reached between provider and the family with respect to confidentiality assume increased importance.

Protecting Confidentiality in Managed Care Settings

In recent years, there has been a dramatic increase in managed care, both as a service delivery method and as a financing mechanism. Increasing numbers of families - both those who are covered by private insurance and those covered by Medicaid - are receiving their care in settings such as staff model health management organization (HMOs) or through plans which use some form of managed care arrangement to restrict choice of providers, capitate costs, and perform gate keeping functions. Each of these situations pose problems for protecting a minor's confidentiality. Some adolescents are concerned that when other family members receive care from the same HMO or from the same primary care provider in a preferred provider network, confidential information may be shared with parents. Youth who receive care at sites such as school-based health clinics which may subcontract with managed care entities, may be concerned about the extent to which information communicated to the managed care plan will remain confidential. Unless adolescents can be assured that confidentiality will be maintained, or have the option of seeking care from other sources, they may avoid utilizing health services that would be otherwise accessible to them.

Legal Limits of Confidentiality

There are circumstances in which it is neither possible nor appropriate to maintain the confidentiality of information for legal and other reasons. These include situations in which the adolescent poses a severe risk of harm to himself or herself or to others, and cases of suspected physical or sexual abuse for which there is a legal reporting requirement. In addition, as previously mentioned, there are situations in which the law requires a health professional to notify the parents when a minor has received care, even care based on her own consent. The most common situations in which this occurs is with respect to abortion and drug or alcohol treatment. It should be remembered that under current constitutional law pertaining to abortion, if a state requires parental notification, it must also permit the minor to seek the alternative of court authorization without parental involvement. Finally, when confidentiality must be breached for ethical or legal reasons, the adolescent must be so informed.

Medical Records

Confidentiality protections apply to written information contained in medical records as well as to information that is communicated verbally between an adolescent and a health care professional. Adult patients, and by extension, mature adolescents who are permitted to consent to their own health care, should be allowed to review their own medical records and to protect their medical records from review by others. However, it is often more difficult to protect the confidentiality of written medical records than to do so for verbal communications—both as a practical matter, and as a result, of certain legal requirements. As electronic medical records are becoming more common, the task of protecting their confidentiality becomes complex.

Numerous legal requirements apply to medical records; many of these embody the same principles of confidentiality that also apply to verbal communications. There are, however, specific provisions that pertain to written records, in general, and heightened protections that apply to particular types of records related to substance abuse or mental health treatment (45). While basic rules of confidentiality apply to medical records, numerous exceptions require disclosure to a variety of funding entities such as Medicare and Medicaid, to other governmental agencies such as law enforcement, or to peer review organizations (45). In addition, with the permission of a patient or legally authorized representative, medical records can be disclosed to a wide variety of persons and entities, particularly insurers (45). Nevertheless a wide range of civil liability and criminal penalties may apply to the unauthorized disclosure of confidential records (45).

The same basic framework applies to medical records documenting health care provided to adolescents. However, when those adolescents are minors and the care involves sensitive issues such as pregnancy, Sexually transmitted diseases, substance abuse, or mental health concerns, disclosure of the records may be subject to specific legal requirements that balance—more or less successfully—the interests of adolescents and their parents. For example, some states have enacted specific provisions that give minor patients the right to decide whether or not to release medical records that pertain to care for which they can give their own consent (46,47). In some cases these laws even require that parents' requests to review such records be refused if the minor objects (46). This is not the case in every state or for all sensitive services, however, and even where such requirement applies, a parent might be able to seek a court order to compel release of the records. Therefore, it is essential to be aware of the requirements of state law.

As a practical matter, most hospitals and outpatient facilities follow a standardized policy that requires authorization from a parent or guardian for the release of records if the patient is below the age of 18 years. In most cases, with parent or guardian authorization, records are released without requiring the permission of the minor adolescent patient or even if the adolescent objects (45). This usually means that a parent or guardian, possibly even including a non-custodial parent, is allowed to review the medical records of a minor child. In some cases such a policy would be consistent with state law; in oth-

ers there might be a legal basis for modifying the policy to entrust greater authority to the minor patient to decide whether records should be released.

Health care professionals who treat adolescents should be aware that protecting the confidentiality of medical records for their patients who are below the age of 18 years is far more difficult than protecting verbal communications. Practitioners should review all requests for disclosure of records related to their adolescent patients and should consider that sensitive or damaging information might be revealed if records are transferred. The clinician who cares for adolescents should seek to ensure that hospital or clinic policies prevent release of records without the permission of the treating professional. When disclosure of records is sought, treating professionals should err on the side of seeking the adolescent patient's permission before releasing the information. In some cases, such as reporting of child abuse pursuant to legal requirements, the caregiver may not have discretion to refuse disclosure. However, in such cases ethical principles would require that the mandatory release of information be explained to the patient. Whenever a clinician feels that releasing records might result in harm to the adolescent patient, consultation with legal counsel should be sought.

Practical Issues

Working to support a confidential relationship with an adolescent in a health care setting requires commitment. This section will review some practical issues and the implementation of confidentiality.

At an appropriate age for the patient, the health provider should set forward a "contract," either verbal, or in writing, so that the patient and parent understand the concept of confidentiality. Most providers discuss this at the beginning of an encounter and reinforce it at later encounters. Some compose a letter to patients and parents at a certain milestone age (12 or 14 years) and describe the changes that adolescent status will confer to the clinician/patient/parent relationship and how it will affect office procedures.

The contract should clarify the basic meaning of confidentiality. For younger adolescents it is necessary to describe in simple language that it means: "What we talk about will be private; I will not discuss it with anyone else." Some adolescents may assume that if you are discussing confidentiality, you must assume they have "secrets." Therefore, it is useful to say, "Our discussion will be private and confidential, even if you don't mind your parents knowing about anything that we talk about."

The conditional nature of confidentiality should be discussed with the adolescent patient. The risk of imminent physical harm or suspected abuse are necessary exceptions to the assurance of confidentiality. It is helpful to use examples that make this understandable. For example, "Everything will be confidential unless something happens, such as if you become suicidal, or you have a severe problem for which you cannot help yourself."

It should be mentioned that clarifying the confidential nature

of the discussion is not a time consuming task. Most providers learn by experience to do this quickly and efficiently. Although this confidential contract is necessary to clarify routinely, adolescents learn to trust the health provider by more than the initial discussion. Every aspect of the relationship, from the first discussion through meeting with the parent after the teenager's examination, to the follow-up phone call, if needed, will show the teen whether the provider can be trusted to follow the confidential agreement.

The parent or parents might wish to give information to the clinician without the teenager in the room. The provider might learn important information from an adult about a behavior that the teen is minimizing, hiding or in denial about. It is best to conduct these meetings after discussing the ground rules with the teen and parent. The provider should attempt to minimize the numbers of these private encounters with parents and to confine them as much as possible to the early stages of treatment. For most encounters, the goal is that everything that concerns the parents should be discussed in their presence. The health professional attempts to improve communication rather than set up separate relationships between physician and parent. This process helps adolescent patients recognize that the care is centered upon their needs and that they will not be excluded. If a provider accepts a parent's request to talk apart from their adolescent, the discussion should be kept confidential.

Health providers have recognized that verbal information is easier to keep confidential than information on the patient's chart. Some state laws mandate release of records to adults who request them. Various approaches have been taken to protecting written information. Some providers have created systems of abbreviations for commonly recorded bits of sensitive information; for example, "SU" to denote : sexually active; unprotected intercourse. Others have kept separate written or computer records with the most sensitive information recorded. It should be remembered that "shadow" files are legally retrievable in the same manner as the standard medical record, if discovered. For practical purposes, most health professionals record the important points of information on the chart in the standard fashion. Every request for records should come to the provider for permission. If there is information that might harm the adolescent if released, the advocacy effort to block the release can be started by postponing signature for the release and seeking legal support.

References are available online at: <http://www.adolescenthealth.org/html/confidential.html>

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CONFIDENTIALITY LITERATURE REVIEW SUMMARIES

1. Council for Scientific Affairs, AMA. “Confidential Health Services for Adolescents,” *JAMA Vol. 269 No.11, March 1993.*

This report reviews adolescents’ need for confidential health services and major barriers to confidential care including the prerogative to provide informed consent for medical treatment and payment for health services. Privacy is generally acknowledged to be essential to a patient’s trust in a health care provider and to a patient’s willingness to supply information candidly. Recent exceptions to the traditional parental consent requirement have been made to consider adolescents in the armed forces, those living away from home or those considered emancipated minors. The legal need for parental consent triangulates the adolescent patient-physician relationship by bringing a third party into health care decision making. Confidential health care may ultimately be compromised by economic realities. Few adolescents can afford to pay for their own medical care, and few physicians can provide subsidized care on a regular basis. The article recommends that 1) providers reaffirm that confidential care for adolescents is critical to health improvement, 2) physicians involve parents in the medical care of their teens, 3) physicians discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated, 4) health care payers develop a method of listing of services that preserves confidentiality for adolescents, and 5) state medical societies review laws on consent and confidential care for adolescents and eliminate laws that restrict the availability of confidential care.

2. Ford, Carol A., MD, et al. “Foregone Health Care Among Adolescents,” *JAMA Vol. 282 No. 23, December 1999.*

No annual national population estimates exist of the number of adolescents who think they need but do not receive health care or of their risk of health problems. Ford, et al. describe the proportion of young people who report foregone health care each year and the influence of sociodemographic factors, insurance status, past health care, and health risks/behaviors on the foregone care. Cross-sectional analyses of data from the 1995 National Longitudinal Study of Adolescent Health showed that on average, 18.7% of adolescents reported foregone health care within the past year. Factors associated with decreased risk of foregone care included continuous private or public insurance, or a physical examination within the past year. Factors associated with increased risk of foregone care included older age, minority race/ethnicity, single-parent household, and disability. In addition, adolescents who reported daily cigarette use, frequent alcohol use, and sexual intercourse were more likely to report foregone care. The results of this study suggest that adolescents who forego care are at increased risk of physical and mental health problems. If health care professionals are to address major causes of adolescent morbidity and mortality, strategies are needed to decrease foregone care. Factors that influence adolescents to forego care must be considered when designing systems to address adolescents’ unique health needs.

3. Ford, Carol A., MD, et al. “Influence of Physician Confidentiality Assurances on Adolescents’ Willingness to Disclose Information and Seek Future Health Care,” *JAMA Vol. 278 No.12, September 1997.*

As part of a larger study on asymptomatic genital Chlamydia, Ford, et al. examines adolescents’ willingness to be tested for sexually transmitted diseases (STDs) under varying confidentiality conditions. Participants

between the age of 15 to 24 completed an anonymous written survey measuring willingness to provide specimen for STD testing as part of routine health care under three different confidentiality conditions: if their parents 1) would find out; 2) might find out; or 3) would not find out that they were tested. Of 1,114 subjects enrolled in the larger study, 72% consented to participate in this questionnaire. Nearly all (92%) reported they would agree to STD testing if their parents would not find out. Significantly fewer would agree to testing linked to potential (38%) or definite (35%) parental notification. More male than female subjects were willing to agree to testing linked to potential or definite parental notification (49.5% vs. 33%). It is significant that the vast majority of sexually active adolescents report they would agree only to confidential STD testing. Privacy concerns may place infected female adolescents at risk of complications. Since most adolescents receive routine health care in private practice or HMO settings, confidential testing should be available at these sites. If physicians' abilities to provide confidential testing are limited because of threats to privacy associated with billing and reimbursement, changes to the systems will be necessary.

4. Reddy, D., et al. "Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services," *JAMA Vol. 288, No. 6, August 2002.*

A study was performed to determine the effect of mandatory parental notification for prescribed contraceptives on use of sexual health care services by adolescent girls. 950 girls younger than 18 seeking services at all 33 Planned Parenthood family planning clinics in Wisconsin were surveyed. 59% indicated that they would stop using all sexual health care services, delay testing or treatment for HIV or other STDs, or discontinue use of specific (but not all) sexual health care services if their parents were informed that they were seeking prescribed contraceptives. Results of the study showed that mandatory parental notification of prescribed contraceptives would impede girls' use of sexual health care services, potentially increasing teen pregnancies and the spread of STDs

5. Akinbami, Lara J., MD, et. al. "Availability of Adolescent Health Services and Confidentiality in Primary Care Practices," *Pediatrics Vol.111, No.2, February 2003.*

The objective of this study was to assess the availability of services for adolescents for medically emancipated conditions, the ability of adolescents to receive confidential care, and the differences between services offered at pediatric versus other primary care practices. Both physicians and office staff at 372 practices within a 25-mile radius of Washington D.C., were queried by telephone and mail surveys. 170 practices had both office staff and physician responses that could be compared. Practice policy was compared with actual service delivery when patients call appointment lines. Investigators asked about services for pelvic exams, contraception, and STD testing. All primary care practice types had significant disagreement between office staff and physicians about availability of confidential services for adolescents and provision of confidential services was low at all sites. Pediatric practices were less likely than Family Medicine (FM) and Internal Medicine (IM) practices to offer services for medically emancipated conditions and a higher agreement between office staff and physicians existed at FM and IM practices. Pediatricians cited lack of expertise, equipment, and low patient demand as reasons for not providing pelvic exams and contraceptive services. Authors suggest that pediatric residents should: 1) receive adequate training in gynecologic skills; 2) be prepared to screen adolescents for risk behavior and; 3) refer adolescents to appropriate care if they are unwilling or unable to provide service. Having a written office policy on confidential services for adolescents was significantly associated with agreement between office staff and physicians about availability of confidential services.

FEDERAL MEDICAL PRIVACY REGULATIONS (“HIPAA RULES”): A BRIEF OVERVIEW

Prepared by the Center for Adolescent Health & the Law

What are the federal medical privacy regulations?

The “Standards for Privacy of Individually Identifiable Health Information” are federal medical privacy regulations (sometimes referred to as the “HIPAA rules”) that broadly regulate access to and disclosure of confidential medical information. These regulations were promulgated by the Department of Health and Human Services (HHS) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

When were the regulations issued?

Proposed regulations were initially published in November 1999. Following the submission of thousands of comments, a final rule was published on December 28, 2000. The effective date of this final rule was postponed until April 14, 2001. Proposed modifications were published in March 2002. Following a public comment period, final modifications were issued on August 14, 2002.

What is the scope of the regulations?

The regulations address a broad range of issues related to the privacy of individuals’ health information. They create new rights for individuals to have access to their health information and medical records and also specify when an individual’s consent is required for disclosure of their confidential health information. The regulations also contain provisions that are specific to the health information of minor children.

Who must comply with the regulations?

The regulations apply to “covered entities,” which include health plans, health care providers, and health care clearinghouses. According to the way each of these is defined in the regulations, the vast majority of health care professionals who provide care to adolescents will be required to comply with the regulations.

When must the new rules be implemented?

Large health plans, health care providers, and health care clearinghouses must comply with the rules by April 14, 2003. Small health plans must comply with the rules by April 14, 2004.

What do the new regulations mean for adolescents?

The new regulations contain numerous provisions that will affect the confidentiality of information regarding health care provided to adolescents. Most of the general provisions of the regulations are relevant. Adolescents who are age 18 or older are adults and have the same rights under the regulations as other adults. In addition, there are provisions of the regulations that address the specific issues related to confidentiality of information for minors, including adolescents who are under the age of 18 and not emancipated. This summary provides only a brief introduction to the provisions pertinent to minors. Detailed information regarding those provisions and information regarding other provisions of the regulations is available from other sources.

What are the specific requirements for adolescents who are minors?

Parents (including guardians and persons acting in loco parentis) generally are considered the personal representatives of and have control over and access to protected health information for their unemancipated minor children. In specific circumstances, parents are not necessarily the personal representatives of their minor children.

When is a parent not the personal representative of his or her minor children?

A parent is not necessarily the personal representative of his or her minor child in one of three specific circumstances; (1) when the minor is legally able to consent for the care for himself or herself; or (2) the minor may legally

receive the care without the consent of a parent, and the minor or someone else has consented to the care; or (3) a parent has assented to an agreement of confidentiality between the health care provider and the minor. In these circumstances, the minor may exercise many of the rights under the regulations. In these circumstances, the minor also may choose to have the parent act as the personal representative or not.

What happens when a parent is not the personal representative?

When a parent is not the personal representative of the minor, the minor may exercise most of the same rights as an adult under the regulations. With respect to the question of whether a parent who is not the personal representative of the minor may have access to the minor's confidential information ("protected health information"), the regulations defer to state or other law. If state or other law explicitly requires or permits information to be disclosed to a parent, the regulations allow a health care provider to comply with that law and to disclose the information. If state or other law prohibits disclosure of information to a parent, the regulations do not allow a health care provider to disclose it. If state or other law is silent on the question, a health care provider has discretion to determine whether or not to grant access to a parent to the protected health information.

What do the regulations mean for health care providers in California?

California has numerous laws that allow minors to give their own consent for health care. In addition, California has laws that specify the circumstances under which parents may or may not have access to information regarding the care for which minors may give their own consent. The federal privacy regulations would defer to those California laws. For adults, including adolescents age 18 or older, the federal regulations defer to state laws that provide stronger privacy protections than the federal rules do. Many other provisions of the regulations would remain applicable to health care providers in California.

What happens if a parent is suspected of domestic violence, abuse, or neglect?

When a parent is suspected of domestic violence, abuse, or neglect of a child, including an adolescent, a health care provider may limit the parent's access to and control over protected health information about the child by not treating the parent as the personal representative of the child.

Where is additional information available that explains the regulations?

Implementation of the regulations is being overseen by the Office for Civil Rights (OCR) within HHS. OCR has established a web site with comprehensive information about the implementation of the regulations: <http://www.hhs.gov/ocr/hipaa/>. The Health Privacy Project at Georgetown University also maintains a web site with extensive information and links regarding the regulations: http://www.healthprivacy.org/newsletter-url2305/newsletter-url_show.htm?doc_id=33936.

What are the official citations for the regulations?

Standards for Privacy of Individually Identifiable Health Information: Final Rule, 65 Federal Register 82461 (Dec. 28, 2000); and Standards for Privacy of Individually Identifiable Health Information: Final Rule, 67 Federal Register 53182 (Aug. 14, 2002). The original rule and the modifications will be merged and codified at 45 Code of Federal Regulations Parts 160 and 164. In the meantime, the August 2002 modifications must be read together with the December 2000 version of the rules to understand the full range of what is required.

How does a health care provider know what is required?

This overview does not provide legal advice. Health care providers should consult with legal counsel to be sure they are aware of the specific requirements of the regulations that apply to them and how to comply with those requirements.

CONFIDENTIALITY AND MINOR CONSENT-RELATED RESOURCES AVAILABLE ONLINE

- **National Center for Youth Law**

<http://www.youthlaw.org>

See Articles and Analysis about Adolescent and Child Health

CA Minor Consent Laws – National Center for Youth Law, 8/01

<http://www.youthlaw.org/CaMinorConsentLaws.pdf>

CA Minor Consent Laws: Who can consent for what services and providers' obligations

<http://www.youthlaw.org/MinorConsentandObligations.pdf>

An Analysis of Assembly Bill 327: New CA Child Abuse Reporting Requirements for Family Planning Providers, 5/98

<http://www.youthlaw.org/AB327.pdf>

- **Advocates for Youth**

<http://www.advocatesforyouth.org>

See Recent Publications

Adolescent Access to Confidential Health Services, 1997

<http://www.advocatesforyouth.org/publications/iag/confhlth.htm>

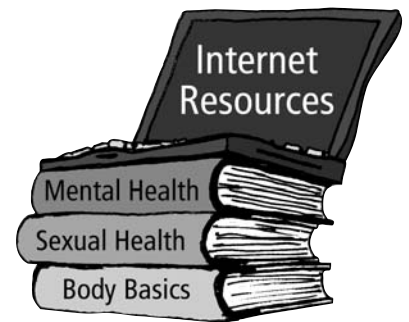
- **Society for Adolescent Medicine**

<http://www.adolescenthealth.org>

See Publications

Confidential Health Care for Adolescents

<http://www.adolescenthealth.org/html/confidential.html>



- **California Adolescent Health Collaborative**

<http://www.californiateenhealth.org/>

See Strategic Plan

Investing in Adolescent Health: A Social Imperative for California's Future

<http://www.californiateenhealth.org/strategic.html>

- **California Healthcare Association**

<http://www.calhealth.org/>

See Publications and Manuals

Minors and Health Care Law: A Handbook in Consent for Treatment of Infants, Children, and Adolescents (order form)

<http://www.calhealth.org/public/pubs/gms/minors.html>

