1. End of Life
    a. Date effective – Assembly Bill 15, California End of Life Option Act enacted June 2016
    b. Purpose – allows terminally ill adults resident in the state of California to access medical aid in dying by self-administering lethal drugs, provided specific circumstances are met
    c. Scope – terminally ill adults
    d. Consent - the individual must be over the age of 18 and possessing full capacity to make an independent decision to end his or her own life as well as be able to administer the drugs him or herself.
        i. application must be made to both an attending and consulting physician
            1. and potentially a mental health specialist such as psychiatrist or licensed psychologist if requested by physician
        ii. The patient must also be certified by the physician as having a life limiting illness with estimated less than 6 months to live and other palliative care options must have been previously discussed and considered.
    e. Associated forms
        i. Attending Physician Compliance & Checklist Form
        ii. Consulting Physician Compliance Form
        iii. Request for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner
        iv. Request for an Aid-In-Dying – Interpreter Declaration
    f. Certain forms are required to be submitted to California Department of Public Health (CDPH):
        i. Within 30 calendar days of writing prescription for medication under EOLA:
            1. Copy of qualifying patient's written request
            2. Attending Physician Compliance & Checklist Form
            3. Consulting Physician Compliance Form
        ii. Within 30 days of qualifying patient's ingestion of aid-in-dying medication obtained under EOLA:
            1. Attending Physician Follow-up Form
    g.
2. Clinical Trials/Research
    a. Code and policy – 21 CFR 50.20, California Health & Safety Code Chapter 1.3 Human Experimentation (§24172, pdf and §24173, pdf)
    b. Purpose – Delineates informed consent
    c. Scope – Individuals who participate in clinical trials
    d. Consent – Informed consent provides potential participants with
        i. Adequate information to allow for an informed decision about participation in the clinical investigation
        ii. Facilitating the potential participant's understanding of the information
        iii. An appropriate amount of time to ask questions and to discuss with family and friends the research protocol and whether they should participate
        iv. Obtaining the potential participant's voluntary agreement to participate
        v. Continuing to provide information as the clinical investigation progresses or as the subject or situation requires
    e. Disclosure to SDHC –

i. there must be a disclosure in the informed consent statement that describes the confidentiality of the information collected during the clinical trials, how records that identify the subject will be kept and the possibility that the FDA may inspect the records,
ii. HIPAA authorization to access or disclose PHI must be signed by subject

f. Associated forms:
i. California Informed Consent Form Checklist
ii. California Research Subject's Bill of Rights

g. Disclosure from SDHC (without individual authorization)
i. May be limited to FDA or Research Advisory Panel of California

3. On Behalf Of
a. Date effective – 1996
b. Purpose – Provide authority for authorized person to consent to medical and/or dental procedure on behalf of another person if that person cannot consent
c. Scope – a minor, incompetent or unconscious person
d. Consent – If not a parent or relative caregiver or guardian (a person legally empowered and charged with the duty of taking care of and managing the property of another person who because of age, intellect or health is incapable of managing his/her own affairs; or an adult authorized in writing to be entrusted to consent to medical or dental care by the parent, legal guardian or relative caregiver
e. Associated Sources and Authority
i. Parent Delegation of Right to Authorize Medical Care. Family Code section 6910
ii. "If the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative." *(Cobbs v. Grant (1972) 8 Cal.3d 229, 244 [104 Cal.Rptr. 505, 502 P.2d 1]; Farber v. Olkon (1953) 40 Cal.2d 503, 509 [254 P.2d 520].)*
f. Disclosure to SDHC – treated as if medical information (PHI)
g. Disclosure from SDHC (without individual authorization)
i. Treatment – treated as if PHI
ii. Payment – treated as if PHI
iii. Operations - treated as if PHI

4. Minors
a. See attachment.

UNDERSTANDING CONFIDENTIALITY AND MINOR CONSENT IN CALIFORNIA

An Adolescent Provider Toolkit

Illustrations by Jordan Zioni, 17

HOW TO OBTAIN A COPY OF THIS TOOLKIT MODULE

This module along with sample polices and handouts in Spanish and Chinese can be downloaded for free from the following websites:
Adolescent Health Working Group (AHWG) – www.ahwg.net
California Adolescent Health Collaborative (CAHC) – www.californiateenhealth.org

ADOLESCENT HEALTH WORKING GROUP

The Adolescent Health Working Group (AHWG) was formed in 1996 by a group of adolescent health providers and youth advocates concerned about the lack of age-appropriate health services in the city of San Francisco. Today, the AHWG remains the only group if its kind in San Francisco. The AHWG's vision is that all youth have unimpeded access to high quality, culturally competent, youth friendly health services. The AHWG's mission is to support and strengthen the network of providers working to improve adolescent health. The AHWG's works to fulfill its vision and mission through the following core functions: 1) develop tools and trainings that increase providers' capacity to effectively serve youth, 2) advocate for policies that increase access to health insurance and comprehensive care, 3) convene stakeholders and coordinate linkages across systems to improve information sharing, networking and referral for youth services.

CALIFORNIA ADOLESCENT HEALTH COLLABORATIVE

California Adolescent Health Collaborative (CAHC), a project of The Public Health Institute, is a public-private statewide collaborative with the goal of increasing understanding and support for adolescent health and wellness in California. CAHC's vision is that adolescents and young adults from all California communities are living healthy lives and pursuing positive life options with resources, support, and opportunities from families, communities, schools, and service systems. Core functions include: 1) curriculum development, training, and technical assistance to strengthen the capacity of providers and systems; 2) publications to increase awareness of providers and policymakers and improve policy and practice; 3) advocacy to keep the health and well being of adolescents central to public debate and decision-making; and 4) collaborative development to strengthen partnerships between different disciplines through a common commitment to adolescent health.

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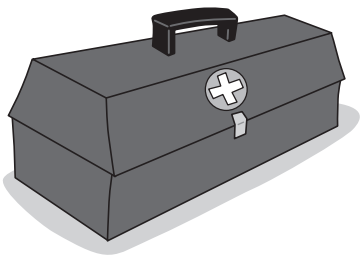
QUESTIONS ON TRAININGS

Contact CAHC: training@californiateenhealth.org
AHWG: info@ahwg.net



CALIFORNIA ADOLESCENTHEALTH COLLABORATIVE

AHWG Adolescent Health Working Group

Dear Colleague,

We are pleased to present you with the second revised edition of **Understanding Confidentiality and Minor Consent in California,** a module of the Adolescent Provider Toolkit series, produced jointly by the Adolescent Health Working Group and the California Adolescent Health Collaborative.

During adolescence, youth confront new issues that affect their physical, reproductive, and mental health. At the same time, establishing autonomy is one of their most vital developmental tasks. As they face these changes, teens crave increased privacy and opportunities to make health-related decisions. This is an appropriate element of healthy development, which, if supported by involved parents and clinicians, can provide an important opportunity for maturation and independence. Youth list concerns about confidentiality as the number one reason they might forgo medical care. For this reason, youth need assurances of privacy and confidentiality with their healthcare providers. However, providers indicate that they are mystified and confused by the various confidentiality and minor consent laws, as well as their child abuse reporting responsibilities. This module, compiled by a multi-disciplinary group of health care providers, lawyers, health educators, social workers, with important input from parents and youth, strives to clarify these issues.

Designed for busy providers, the new **Understanding Confidentiality and Minor Consent in California** Module 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. This module includes:

- Charts on minor consent and confidentiality
- Practice tools
- Screening, Assessment and referral tools
- Resource sheets
- Health education handouts for teens and their parents/guardians
- Online resources and research

Updates and additions in this new edition include:

- Updated legal information
- Added resources for youth
- A new section for parents/guardians
- Information addressing issues of HIPAA and FERPA

Our two websites have additional examples of forms and health education handouts in Chinese and Spanish for both youth and parents/guardians. This module can be downloaded for free in its entirety.

An interactive live training is also available to integrate the use of the module into clinical practice. Our evaluation data indicates that those who utilize our trainings find the materials richer, more salient, and are more likely to feel confident responding to minor consent and confidentiality concerns in their work with teens.

If you have questions regarding the Toolkit or its accompanying training and resources; please call the California Adolescent Health Collaborative at (510)285-5712 or Adolescent Health Working Group at (415)554-8429.

Regards,

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THE ADOLESCENT MINOR CONSENT and CONFIDENTIALITY PROVIDER TOOLKIT ADVISORY GROUP

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CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS:

MINOR CONSENT SERVICES AND WHEN PARENTS MAY ACCESS RELATED MEDICAL INFORMATION

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
PREGNANCY	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 6925).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
CONTRACEPTION	A minor may receive birth control without parental consent. (Cal. Family Code § 6925).	
ABORTION	A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; *American Academy of Pediatrics v. Lungren*, 16 Cal.4th 307 (1997)).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with parents with a signed authorization from the minor. (*American Academy of Pediatrics v. Lungren*, 16 Cal.4th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUAL ASSAULT[1] SERVICES [1]For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.	"A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard to the …assault." (Cal. Family Code § 6928).	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). Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such. The child abuse authorities investigating the report legally may disclose to parents that a report was made.
RAPE[2] SERVICES FOR MINORS UNDER 12 YRS[3] [2]Rape requires an act of non-consensual sexual intercourse. [3]See also "Rape Services for Minors 12 and Over" on page 3 of this chart	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 with regard" to the rape. (Cal. Family Code § 6928).	

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
EMERGENCY MEDICAL SERVICES* *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)).	A provider shall not be liable for performing a procedure on a minor if the provider "reasonably believed that [the] procedure should be undertaken immediately and that there was insufficient time to obtain [parental] informed consent." (Cal. Bus. & Prof. Code § 2397).	The parent or guardian usually has a right to inspect the minor's records. (Cal. Health & Safety Code §§ 123110(a); Cal. Civ. Code § 56.10. *But see exception at endnote* (EXC.)).
SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT* * The provider does not need the minor's or her parent's consent to perform a procedure under this section.	"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 § 11171.2).	Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.
MINORS OF 12 YEARS OF AGE OR OLDER MAY CONSENT	**LAW**	**CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS**
OUTPATIENT MENTAL HEALTH SERVICES[4]/SHELTER SERVICES [4]This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.	"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).	**MENTAL HEALTH TREATMENT:** The health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii). While this exception allows providers to inform and involve parents in treatment, it does not give providers a right to disclose medical records to parents without the minor's consent. The provider can only share the minor's medical records with a signed authorization from the minor. (Cal. Health & Saf. Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11, 56.30; Cal. Welf. & Inst. Code § 5328. *See also exception at endnote* (EXC). **SHELTER:** 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.

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS:
MINOR CONSENT SERVICES AND WHEN PARENTS MAY ACCESS RELATED MEDICAL INFORMATION, cont.

MINORS OF 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
DRUG AND ALCOHOL ABUSE TREATMENT • 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)).	"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)).	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. **FEDERAL:** Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria: 1. 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 2. The individual or program: 1) Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; OR 2) 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 3) 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). 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). STATE RULE: Cal. Family Code §6929(c). Parallels confidentiality rule described under "Mental Health Treatment" supra at page 2. See also exception at endnote (EXC.).

MINORS OF 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
DIAGNOSIS AND/OR TREATMENT FOR INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES	"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).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11). Rape of a minor is considered child abuse under California law and must be reported as such. Even if health care providers cannot disclose to parents that they have made this report, adolescent patients should be advised that the child abuse authorities investigating the report legally may disclose to parents that a report was made.
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).	
AIDS/HIV TESTING AND TREATMENT	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).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
DIAGNOSIS AND/OR TREATMENT FOR SEXUALLY TRANSMITTED DISEASES	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).	

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS:

MINOR CONSENT SERVICES AND WHEN PARENTS MAY ACCESS RELATED MEDICAL INFORMATION, cont.

MINORS OF 15 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
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). See also exception at endnote (EXC)).
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)	**LAW**	**CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS**
GENERAL MEDICAL CARE	An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). See Cal. Family Code § 7002 for emancipation criteria.	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 information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).

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EXC: Providers may refuse to provide parents access to a minor's medical records, where a parent normally has a right to them, if "the health care provider determines that access to the patient records requested by the [parent or 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.' Cal. Health & Safety Code § 123115(a)(2). A provider shall not be liable for any good faith decisions concerning access to a minor's records. Id.

CALIFORNIA MINOR CONSENT LAWS

SERVICES YOUTH CAN RECEIVE WITHOUT PERMISSION FROM THEIR PARENT/GUARDIAN		CAN PROVIDER TELL YOUTH'S PARENT/GUARDIAN?
Birth Control *Except Sterilization*	Minors of any age	**No** Parental notification allowed only with consent of minor
Pregnancy (Prev, Dx, Tx) *Including inpatient care*	Minors of any age	
Abortion	Minors of any age	
STIs, Contagious and Reportable Diseases (Dx & Tx)	Minors 12 yrs or older	
HIV Testing	Minors 12 yrs or older and assessed as competent to give informed consent	
Sexual Assault Care	Minors of any age	**Yes** In most cases, an attempt to notify parent/guardian must be made. [1,2]
Alcohol/Drug Counseling by Federally Assisted Treatment Program *Including inpatient care*	Minors 12 yrs or older [3,4]	**No** Parental notification allowed only with consent of minor
Alcohol/Drug Counseling by Non-Federally Assisted Treatment Program	Minors 12 yrs or older [3,4]	**Yes** An attempt to notify parent/guardian must be made, except when provider believes it is inappropriate
Outpatient Mental Health Treatment	Minors 12 yrs or older [5]	

DEFINITIONS
(with regard to minor consent)

Confidentiality: The provider can only share patient information with permission of patient. Note: Exceptions include reporting child abuse and insurance billing.

Consent: Giving permission to receive health services; or giving permission to share patient information with others.

Notification: The provider is required to tell a minor's parent/guardian that he/she received a specific health service. Note: Notification does not mean access to medical records.

Sexual assault: For the purposes of minor consent alone, sexual assault includes but is not limited to acts of oral sex, sodomy, rape, and other violent crimes of a sexual nature that occur without permission.

Note: Minors maintain the same right to consent for the above healthcare services upon entry into foster care and juvenile justice systems.
For more detailed information on consenting for healthcare services for youth in the foster care and juvenile justice systems, see: *Consent to Treatment for Youth in the Juvenile Justice System: California Law and Consent to Medical Treatment for Foster Children: California Law* at www.teenhealthrights.org.

Adapted from: CA Minor Consent Laws Pocket Card, the Adolescent Health Working Group.

[1]The law allows for some exceptions to parental notification. These exceptions include suspecting the parent of assault and certain cases of rape. See teenhealthrights.org for more information.

[2]Sexual assault requires a child abuse report in which case youth should be advised that parents may be notified by law enforcement or child protective services.

[3]However, parent/guardian can consent over the minor's objection.

[4]Parent/guardian's consent is required for methadone treatment.

[5]If (1) the minor is 12 years or older, is mature enough to consent AND (2) the minor is (A) the victim of incest or child abuse or (B) would present a threat of serious physical or mental harm to self or others without treatment.

KEY:
Pre=Prevention
Dx=Diagnosis
Tx=Treatment
STIs=Sexual Transmitted Infections

When Sexual Intercourse with a Minor Must Be Reported as Child Abuse: California Law*

In California, health care practitioners are mandated to report any reasonable suspicion of child abuse. Sexual intercourse with a minor is reportable as child abuse:

1. WHEN COERCED OR IN ANY OTHER WAY NOT VOLUNTARY

Mandated reporters must report any intercourse that was coerced or in any other way not voluntary, irrespective of the ages of the partners and even if both partners are the same age. Sexual activity is not voluntary when accomplished against the victim's will by means of force or duress, or when the victim is unconscious or so intoxicated that he or she cannot resist. See Penal Code § 261 for more examples. Irrespective of what your patient tells you, treating professionals should use clinical judgment and "evaluate facts known to them in light of their training and experience to determine whether they have an objectively reasonable suspicion of child abuse." 249 Cal. Rptr. 762.

2. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND PATIENT IN A FEW SITUATIONS

Mandated reporters also must report based on the age difference between the patient and his or her partner in a few circumstances, according to the following chart:

KEY: M = *Mandated. A report is mandated based solely on age difference between partner and patient.*
CJ = *Clinical Judgment. A report is not mandated based solely on age; however, a reporter must use clinical judgment and must report if he or she has a reasonable suspicion that act was coerced, as described above.*

AGE OF PATIENT	AGE OF PARTNER										
	12	13	14	15	16	17	18	19	20	21	22 and older
11	CJ	CJ	M	M	M	M	M	M	M	M	M ⇨
12	CJ	CJ	M	M	M	M	M	M	M	M	M ⇨
13	CJ	CJ	M	M	M	M	M	M	M	M	M ⇨
14	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇨
15	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇨
16	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
17	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
18	M	M	CJ	CJ	CJ	CJ					
19	M	M	CJ	CJ	CJ	CJ					
20	M	M	CJ	CJ	CJ	CJ					
21 and older	M	M	M	M	CJ	CJ					

Chart design by David Knopf, LCSW, UCSF.
The legal sources for this chart are as follows: Penal Code §§ 11165.1; 261.5; 261; 259 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1st Dist. Ct. App. 1986); 73 Cal. Rptr. 2d 331, 333 (1st Dist. Ct. App. 1998).

DO I HAVE A DUTY TO ASCERTAIN THE AGE OF A MINOR'S SEXUAL PARTNER FOR THE PURPOSE OF CHILD ABUSE REPORTING?

No statute or case obligates health care practitioners to ask their minor patients about the age of the minors' sexual partners for the purpose of reporting abuse. Rather, case law states that providers should ask questions as in the ordinary course of providing care according to standards prevailing in the medical profession. Thus, a provider's professional judgment determines his practice. 249 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1988).

WHAT DO I DO IF I AM NOT SURE WHETHER I SHOULD REPORT SOMETHING?

When you aren't sure whether a report is required or warranted, you may consult with Child Protective Services and ask about the appropriateness of a referral.

*This worksheet addresses reporting of consensual vaginal intercourse between non-family members. It is not a complete review of all California sexual abuse reporting requirements and should not be relied upon as such. For more information on other reporting rules and how to report in California and other states, check www.teenhealthrights.org

CONFIDENTIALITY AND MINOR CONSENT Q&A

Q: What are the services a minor can consent to?	**A:** See pages 2-8 "CALIFORNIA MINOR CONSENT LAWS: Who can consent for what services and providers' obligations."
Q: If a minor cannot give consent to health care, who (besides a parent) can give it for them?	**A:** ***Adult Caretaker:*** With letter from parent, or with a caretaker 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:*** In some cases. ***Emergency:*** Consent not required in an emergency Note: For complete information, please refer to http://www.teenhealthrights.org/
Q: How far should I go when trying to reach a parent?	**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, decisions, and rationale for treatment or interventions.
Q: Can consent be given verbally?	**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. (See Back Office Policies, p.15)
Q: If parents give consent to treatment, does that give them the right to look over medical records?	**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.
Q: When the youth has the right to confidential care, what do I do if I'm uncomfortable NOT telling parents?	**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 on pages 2-6 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. 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.

CONFIDENTIALITY AND MINOR CONSENT Q&A, cont.

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

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 Medi-Cal Minor Consent program and bill for services through this program.
(3) Refer your patients to Family PACT or Medi-Cal Minor Consent providers. See page A-18, "Financing Sensitive Services: A Guide for Adolescent Health Care Providers."
(4) Contact the patient's health plan and let them know your concerns.
(5) Urge your patients to request that their insurer not send an EOB or send it to a different address, although the insurer is not obligated to comply.

Q: I know that minors 12 and over 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. For more detailed information, please refer to "Behavioral Health: An Adolescent Provider Toolkit" at www.ahwg.net.

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, and 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 for breaching confidentiality if they make a good faith report of abuse.

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

A: See page A-8 "When Sexual Intercourse is Reportable as Child Abuse in California?"

Q: How do I make a report?

A:

1. Reports should be made to any one of the following:
   - any police department or sheriff's department, not including a school district police or security department;
   - the county probation department, if designated by the county to receive mandated reports; or
   - the county welfare department (often referred to as CWA or CPS).
2. You must make an initial report immediately or as soon as is possible by telephone. A written report (DOJ form SS 8572) must be sent, faxed, or electronically transmitted within 36 hours of the verbal report.

MANDATED REPORTING Q&A, cont.

Q: What will I report?	**A:** 1. Your name. Although this is kept confidential, there are exceptions 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 requested by the child protective agency, including what led you to suspect child abuse. 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 report?	**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. A dependency case may be opened.
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.

IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS? OFFICE SELF-ASSESSMENT CHART

			YES	NO
STAFF	**Knowledge**	Staff are educated regarding the confidentiality laws that pertain to adolescents (p. 2-11 of toolkit). Reference materials are available for all staff.		
	Policies	When confidentiality cannot be maintained, adolescents are provided referrals to other practices where confidentiality will be safeguarded.		
	Practice	Charts and paperwork are securely placed or stored.		
		Patient information is only discussed in private and never in elevators, hallways, parking lots, garages, waiting rooms, or other open spaces.		
WAITING ROOM	**Privacy**	Precautions are taken to ensure privacy when patients register at the front desk.		
		Patients can sit in visually obscured, private areas (i.e. a corner or alcove; behind a room divider), and are shielded from the view of people walking outside.		
		Waiting room signs assure confidentiality.		
	Environment	The atmosphere (pictures, posters, etc.) creates a safe and comfortable environment for adolescents to discuss private health concerns.		
		Patients are given as much privacy as possible when completing forms and paperwork.		
HAND OUTS AND MATERIALS	**Discrete**	Literature is small enough to fit into a purse or wallet.		
	Accessible	Educational materials on confidentiality for adolescent patients and their parents are displayed and/or offered.		
		Written materials have been translated to languages spoken by patients and families.		
		Written materials have been assessed for reading levels and some materials target adolescents with a reading level below 8th grade.		
EXAM	**Informative**	Adolescents and parents are provided with the opportunity to talk one-on-one with the health care provider about their concerns.		
		At the beginning of each appointment, the parameters of confidentiality are explained to patients and his/her parents.		
		Situations in which confidentiality may be breached are discussed.		
		A sign in the exam room encourages patients to ask questions.		
	Private	Patients are given privacy when changing clothes.		
		Doors are closed during history taking, counseling, and physical exams.		

IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS? OFFICE SELF-ASSESSMENT CHART, cont.

			YES	NO
IN-HOUSE RECORD KEEPING*	**HIPAA Compliant**	File cabinets, drawers, and file rooms are closed and locked when not in use.		
		Adolescent charts are flagged with a sticker stating "DO NOT COPY," and staff are trained to separate out confidential materials when copying records.		
		Confidential visit information is filed in a separate or distinctly marked section of the medical record.		
	Electronic Records	Computer access is protected by passwords, and monitors are faced away from public view.		
PRE-VISIT AND FOLLOW UP	**Phone Calls**	New adolescent patients can join your practice without parental consent when legally possible.		
		Patients are asked at the time of scheduling if automated appointment reminder calls are ok.		
		At every visit, adolescent patients are asked where and how they can be contacted by phone or email for general and/or confidential matters.		
	Mail	Appointment reminders are only mailed to adolescent patients' homes with permission from the adolescent. If the adolescent does not wish to receive mail at home or an alternate address, he or she is offered a time to pick up mail at the clinic.		
BILLING	**Procedures**	Special considerations are made to safeguard confidential visit information for adolescents with private insurance. Please see p. 15 of toolkit.		
		Payment for confidential services is collected at the time of service if possible.		

HOW DID YOU SCORE?

If you checked more than half of the boxes "yes" in each section, you're on your way to having a confidentiality conscious office. Each section in which you checked only half or less of the boxes "yes" should be improved to better promote and protect confidentiality in your office. You can improve your office by implementing each piece that you checked "no."

*While establishing confidentiality conscious guidelines in the front office is essential, it is also important to acknowledge that confidentiality can be breached through the systems that support your electronic record keeping, billing, insurance claims, and explanation of benefits (EOBs). See the Back-Office Policy Recommendations (p.15) for suggestions on confidentiality conscious policies for the systems in your type of practice.

CONFIDENTIALITY CONSCIOUS BACK-OFFICE POLICY RECOMMENDATIONS

The following administrative policies are necessary in any practice setting for the promotion and protection of adolescent confidentiality. Exemplary policies from various health care settings can be found at www.californiateenhealth.org.

COMMUNICATION AMONG FRONT AND BACK OFFICE STAFF

- Clinician/Provider: The clinician stamps or visibly marks the chart of each adolescent patient who receives minor consent services. Clearly marking charts that contain confidential information is imperative so that all personnel (including registration and lab) are aware that adolescents' confidentiality must be maintained.
- Front and Back Office Staff: All staff are trained to look for confidential charts and treat them accordingly.

SENSITIVE BILLING PRACTICES

- For confidential services, request any co-payment at the time of service. If the adolescent patient cannot pay at the time of visit, a balance is incurred that can be paid in person at a later date or alternately, waiving the fee.
- Electronic or automatic billing programs can be circumvented by using alternate programs or methods of record keeping for paying for confidential services.

DIFFERENT TYPES OF PRACTICES WILL REQUIRE ADDITIONAL OR SPECIALIZED POLICIES.

Special Considerations for Privately Insured Patients

While Medi-Cal and other types of public coverage generally avoid sending explanation of benefits (EOB) to patients' homes for confidential or sensitive services, private insurance companies are often required to send EOBs as a measure to avoid fraud. Even if billing to the home is avoided, an EOB sent home can breach confidentiality for adolescents who are insured through their parents. In general, *providers* have little to no control over how insurers will inform their beneficiaries of claims, but HIPAA allows *patients* to request that his or her insurance plan not send an EOB to the household if disclosing the information to another household member will "endanger" the patient.

POLICY RECOMMENDATIONS:

- Ensure that patients seeking confidential or sensitive services are aware that they may request that their insurer not send an EOB or send it to a different address if the disclosure would "endanger" the patient. Note that the insurer is not obligated to comply with the request. Adolescent patients may not know what type of insurance they have, so the following recommendation should be simultaneously implemented.
- Train billing, claims, or other appropriate staff to flag or contact privately insured patients receiving confidential care to warn them that an EOB containing information may be sent to their home address. Patients receiving confidential services who feel they would be endangered by receiving an EOB to the household should be encouraged to contact their health plan's HIPAA-required privacy officer for information on how to make a request.

ELECTRONIC RECORDS

- Face monitors away from public and other employee view, or use privacy screens, strategically placed objects, or timed screen savers and log-outs.
- Use passwords, and enforce no password sharing or accessible written passwords.
- When communicating between electronic systems, use a real or virtual cover sheet with a confidentiality notice and request to destroy if sent unintentionally.
- When disclosing medical records of a minor to the parent of that minor, confidential minor-consent services are NOT automatically printed or included.

PROMOTION OF SERVICES

- Advertisement wallet cards are adolescent-appropriate and state confidentiality practices.
- Publicize your services at local schools.

Balancing Act: Engaging Youth, Supporting Parents

Attempting to provide confidential services can cause great discomfort for adolescents, parents, and providers if it is not handled in a sensitive manner. The following are recommendations to ease the transition from the parent-accompanied visit to the confidential adolescent visit. The participation of a parent/caregiver in the adolescent's visit is invaluable and should be encouraged. That said, essential information may not be disclosed if the provider does not establish rapport and an alliance with the adolescent. When balancing the needs, concerns, and priorities of the parent with those of the adolescent, remember, the *adolescent* is your client, not the parent.

SEPARATING THE ADOLESCENT AND PARENT IN THE CLINICAL 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 talk 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 adolescent and parent.*

  ***Normalize** the reality that adolescents have an increased concern with and need for privacy.*

  ***Acknowledge** that although the adolescent is a minor, they do have 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 <u>all</u> adolescents in your practice or clinic (in other words, this is not specific to a particular adolescent).*

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

SEPARATE

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

ESTABLISHING A RELATIONSHIP WITH THE ADOLESCENT:

REVISIT

- Once the parent is out of the room, revisit issues of consent and confidentiality with the adolescent, including situations when confidentiality has to be breached (suicidality, abuse, etc.).
- Revisit areas of parental concern with the adolescent and obtain the adolescent's perspective.

EXAM

- Conduct the psycho-social interview and physical exam (ascertain whether the adolescent desires parent's presence during PE and accommodate adolescent's preference).
- Decide what to disclose and how; clarify what information from the psycho-social interview and PE the adolescent is comfortable sharing with parent.
- Encourage the adolescent to discuss issues with their parent or other responsible adult as appropriate to the individual circumstances.
- Explore approaches the adolescent might use to facilitate this discussion (how do they imagine the conversation).
- Offer support, tools and facilitation.

CONCLUDING THE VISIT WITH THE ADOLESCENT AND PARENT

REUNITE

- Invite the parent back to close the visit with both parent and adolescent.
- Focus on strengths and discuss concerns (with the adolescent's permission).

TIPS

- Give parents and adolescents a heads up about confidential care. Send a letter to all adolescent patients and their parents who are new or between 10-11 years old explaining your policy. This will help prepare families for the adolescent visit.
- Explain the separation of the parent and adolescent by emphasizing that adolescents need to have increasing involvement in and **responsibility** for their health**.**
- A young person is more likely to disclose sensitive information to a health care provider if the adolescent is provided with confidential care, and has time alone with the provider to discuss his/her issues.
- Even when the presenting concern is acne or an earache, there may be other issues (such as the need for a pregnancy test or contraception), which will only surface when confidential care is provided.
- Display posters in the waiting area explaining adolescent consent and confidentiality and your office policy relating to the law. This can reinforce that you will be meeting alone with the adolescent.

Provider Tips for Discussing Conditional Confidentiality

Be direct

- Discuss confidentiality and the conditions under which it might be breached at the beginning of your interaction with a young person.

Keep it simple

- Tailor your discussion to the youth's age and context. For example, when presenting information about child abuse reporting related to age differences:

  In California for the 13 year old client, it is important to emphasize that if they tell you that they are having sex with a partner who is older than they are, you would need to report that as child abuse, *even if they tell you they are having consensual sex, in order to assure that they can get help if they need* it.

  In California for the 16 year old client, the focus would shift to a discussion of his or her risk of being reported as a perpetrator of child sexual abuse if they tell you that their partner is under 14 years old.

Communicate caring and concern

- Always frame information about your need to breach confidentiality (child abuse reporting, informing others about a youth's suicidality) in the context of "getting them the help that they might need", rather than using the law, policy, or phrase "I am a mandated child abuse reporter," as a reason to breach confidentiality.

Assure two-way communication

- Clarify that you will ALWAYS let the youth know if you are going to share information that they told you in confidence.

Know the law

- Be *very* familiar with California laws related to minor consent and confidentiality. In order to explain content clearly, you must first understand it yourself.

Check for understanding

- Ask the youth to explain what *they* understand about conditional confidentiality to avoid any misperceptions.
- If you're unsure about a situation or question that comes up about confidentiality, let the client know that you need to check out the facts and then get back to them in a timely fashion.

Document your communications, understanding and actions in the medical record

Financing Sensitive Services: A Guide for Adolescent Health Care Providers

Payment for sensitive services (i.e. STI testing and treatment, pregnancy related services, and behavioral health care) can pose an enormous barrier to youth seeking confidential care. Young people may not have enough money to pay for services that they need. Often, they are also worried that if they access services through their parent's insurance or free and low-cost programs, such as Family PACT (Planning, Access, Care and Treatment) and Minor Consent Medi-Cal, that their confidentiality will be compromised.

Use of Evidence of Benefits (EOB) Statements is another potential barrier that can affect billing choices for providers and use of services for adolescents. These statements, which typically list the type and nature of services billed for and reimbursed by the insurer, are generally mailed to the policy holder (parent). As a result, confidentiality may be violated. **Insurance company policies and state law, not individual provider preference, determine whether EOBs are sent to the policy holder.**

California has two unique 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. These two programs do not send out EOB's.

KEY DIFFERENCES BETWEEN MEDI-CAL MINOR CONSENT AND FAMILY PACT (TITLE X):

1. While both programs cover pregnancy testing, Family PACT does not cover abortion or care once pregnant. Medi-Cal Minor Consent covers these services.
2. Family PACT covers females 55 and under and males 60 and under. Medi-Cal Minor Consent provides coverage for females and males up to age 21.
3. Clients must enroll in Family PACT at an FPACT provider's office. Clients can enroll for Medi-Cal Minor consent with an eligibility worker, who may or may not be located in a clinical setting.
4. For Family PACT, eligible clients are activated for one year following application and reconfirmed at each date of service; clients using Medi-Cal Minor Consent services must renew their eligibility every 30 days.

RESOURCE FOR ADDITIONAL INFORMATION

Fox, H. and Limb, S. "State Policies Affecting the Assurance of Confidential Care for Adolescents" (April 2008)
This fact sheet is a comprehensive overview of state's minor consent laws, explains how and why EOBs are used, and addresses implications of these policies for adolescents and providers. http://www.thenationalalliance.org/jan07/factsheet5.pdf

Financing Sensitive Services: A Guide for Adolescent Health Care Providers, cont.

	MEDI-CAL MINOR CONSENT	FAMILY PACT (Title X)
SERVICES COVERED	• Pregnancy and pregnancy-related services, including abortion • Family planning (birth control), including emergency contraception • Drug and alcohol counseling and treatment • Sexually transmitted infection testing and treatment • Sexual assault treatment	• Pregnancy testing, counseling and referral • Family planning methods, including birth control and emergency contraception • Sexually transmitted infection testing and treatment • Education and counseling about reproductive health • HIV testing and counseling • Referrals for other services
CLIENT ELIGIBILITY (Age)	12 to 21	Females 55 and under; Males 60 and under
CLIENT ELIGIBILITY (Income)	Any income	200% of federal poverty level or less
CLIENT ELIGIBILITY (Citizenship)	Must be a California resident	Must be a California resident
INFORMATION REQUESTED FROM CLIENT	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.
CLIENT CO-PAY	None	None
HOW A YOUNG PERSON CAN UTILIZE THIS PROGRAM	Patient must visit the local county Social Services Office where eligibility is determined. Locations and phone numbers can be found at: www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx	Patient must visit a Family PACT provider, who will enroll the youth in the program. Services can be accessed immediately.
FOR MORE INFORMATION	Check the Medi-Cal website: www.medi-cal.gov or call the Medi-Cal Telephone Service Center (TSC) 1-800-541-5555.	The Family PACT website has comprehensive links to all aspects of the program: http://www.cdph.ca.gov/programs/FamilyPact/Pages/default.aspx A toll-free resource number provides information in both English and Spanish. 800-942-1054
HOW CAN A CLINIC BECOME A PROVIDER	Practitioner must be a Medi-Cal provider. Call 1-800-541-5555 or visit www.medi-cal.gov to download the provider application form.	A one page PDF on the Family PACT website includes phone numbers and resources for clinics and providers. A one-day orientation to the program is required. Contact the California Office of Family Planning at (916) 650-0414 for information. http://www.cdph.ca.gov/programs/FamilyPact/Documents/MO-AssistancePhoneCallAway07-08.pdf

Notes

The following pages consist of handouts for use with your adolescent patients and their parents. It is important to remember that these documents are intended to be used in conjunction with your visits—they are NOT a substitute for discussing these issues.

Youth materials are denoted with this symbol: 

Parent materials are denoted with this symbol: 

These handouts are also available in Spanish and Chinese on the websites of Adolescent Health Working Group (AHWG) www.ahwg.net and California Adolescent Health Collaborative (CAHC) www.californiateenhealth.org

We hope that these materials will offer guidance and spark discussion!

AHWG has additional materials for use with youth and parents in their other Toolkit modules. All toolkit modules can be downloaded from the website listed above.

YOUTH

The TRUTH ABOUT Confidentiality

Confidentiality means privacy.

Confidential health care means that information is kept private between you and your doctor or nurse.

Your doctor or nurse CANNOT tell your parents or guardians about your visits for:

- Pregnancy
- Birth control or abortion
- Sexually transmitted diseases (STDs)

For your safety, some things *CANNOT* stay confidential. Your doctor or nurse has to contact someone else for help if you say…

- You were or are being physically or sexually abused.
- 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.

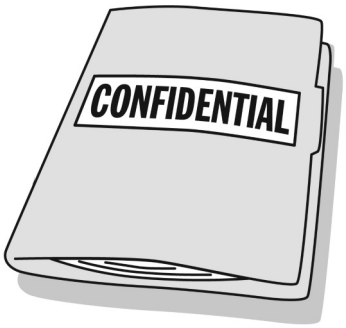
CONFIDENTIALITY TIPS FOR TEENS

Ask questions about confidentiality. You can ask your doctor or nurse and health insurance plan what information will be shared with your parent/guardians.

Know your rights in the health care system and speak up.

Read and understand forms before you sign them.

Even if you do NOT need permission from your parent/guardian to see a doctor, it's a good idea to talk with them or a trusted adult about the help you need.



Every state has different confidentiality laws. This information applies ONLY to California. Visit www.teenhealthrights.org for more information about laws that protect your privacy when talking to your health care provider.

Teens...
Did You Know?

Anything you say about sex, drugs and your personal feelings is confidential.*

There are some exceptions so ask your doctor about confidentiality rules.

What we say here stays here

*Visit www.teenhealthrights.org for more information about laws that protect your privacy when talking to your healthcare provider.

Teen Health Rights and Responsibilities

An Agreement Between You and Your Doctor

As a teen,

I have the RIGHT to:

- Be treated with respect.
- Be given honest and complete health information.
- Ask questions.
- Know how my health insurance and billing process works.
- Be able to look at my medical records.
- Ask for any of my family, friends, or partners to come into the exam room with me.
- See my doctor without my parent/guardian in the exam room.

I have the RESPONSIBILITY to:

- Give honest information and let my doctor know if my health changes.
- Follow the plan that I choose with my doctor or nurse, and tell him/her if I choose to change my plan.
- Treat staff, other patients, and the office with respect.
- Be on time for my appointments and call if I need to cancel or change an appointment.

When I have questions, I will **ASK!**

When I have concerns, I will **SPEAK UP!**

When I like what happens, I will **SMILE AND SAY THANKS!**

How Well do you Know Your Health Rights and Responsibilities?

TRUE OR FALSE:

A teen can see a doctor about birth control and pregnancy without their parent/guardian's consent.

TRUE: California has laws that let a person of any age make their own choices about birth control, pregnancy, abortion, adoption, and parenting.

Teens 12 and older can see a doctor about mental health issues, drug and alcohol use, or sexually transmitted diseases without their parent's consent.

TRUE: California laws let people 12 or older get care for mental health, drug and alcohol issues, or sexually transmitted diseases without parent consent.

Not all issues a teen might want to see a doctor for are considered confidential.

TRUE: Cases of abuse, assault, or possible suicide cannot remain confidential. Your doctor may have to contact others for help. Health services like treatment of injuries, colds, flu, and physicals are NOT confidential services. The doctor will need your parent/guardian's consent for these services.

A teen can ask a doctor about what will stay private in a visit, and what information will be shared with parents/guardians.

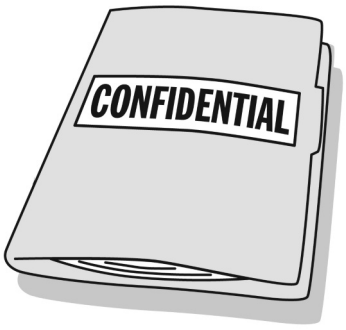
TRUE: There are many laws about what information your parent/guardian will be given. It is important to talk to your doctor about what will stay private. In some situations, you get to decide what is shared.

It is usually helpful for a teen to talk to an adult they trust about their health or changes in their life that they are worried about.

TRUE: It can be helpful to talk to an adult you trust such as a parent/guardian, teacher, family friend, counselor, or coach about your health. If there are health issues you have questions or concerns about, a trustworthy adult can give you important advice and opinions.

A teen being responsible for his or her health is an important part of growing up!

TRUE: Taking on more responsibility and wanting more privacy are a normal part of growing up for teens.



A Letter From Your Teen's Health Care Provider

Dear Parent or Guardian,

As teens become adults and take more control of their lives, our office will ask them to be more actively involved in their health and health care.

Some areas of teen health that we may talk about during an exam are:

- Eating and how to be active
- Fighting and violence
- Sex and sexuality
- Safety and driving
- Smoking, drinking, and drugs
- Sadness and stress

You should know…

We support teens talking about their health with their parents or guardians. But teens may be embarrassed to have an exam or talk about some things in front of their parents. This is a normal part of growing up. We give all teens a chance to be seen privately. During this time, you will be asked to wait outside of the exam room.

In order to best take care of your teen we offer some confidential services. "Confidential" means that we will only share what happens in these visits if the teen says it is okay, or if someone is in danger.

In California, teens can receive some types of health services on their own. We cannot share the content of these visits without your teen's okay. Ask us about what these health services include.

We are happy to talk to you about any questions or concerns you may have about this letter and your teen's health. Together, we can help keep your teen healthy.

Below, you will find some helpful websites about teen health and tips for parents of teens.

Sincerely,

Your teen's Health Care Provider

RESOURCES

Children Now and Kaiser Family Foundation
http://www.talkingwithkids.org

Advocates for Youth
http://www.advocatesforyouth.org/

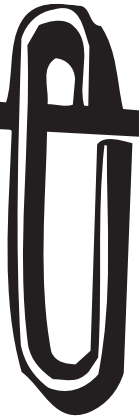
SIECUS– Families are Talking
http://www.familiesaretalking.org

California Family Health Council–Talk with Your Kids
http://www.talkwithyourkids.org/

US Department of Health & Human Services–Parents Speak Up
http://www.4parents.gov/

Nickelodeon–Parents Connect
http://www.parentsconnect.com

PARENT



A Note to Parents from your Teen's Doctor

- Teens need to have more input in their health in order to build responsibility.
- I will give your teen a chance to talk to me alone during each exam.
- In California, teens can receive some services on their own. I cannot talk to you about your teen's use of these services without permission from your teen. Talk to me about what these services are.
- I encourage teens to talk about their health with their parents.
- I am happy to answer any questions or concerns you may have!

PARENT

YOUR TEEN IS CHANGING!

The teen years are a time of growth and change as your teen moves from being a child to an adult.

As your teen changes, your role as a parent changes. You will relate to your 12 year old differently than your 18 year old. It is important to know what to expect, so that you can give your teen more responsibility and the best possible advice.

YOUR TEEN MIGHT:

- Become more independent
- Want more responsibility
- Push boundaries and test limits
- Want their relationship with you to change
- Need more privacy
- Have mood swings
- Think a lot more about their own personal concerns
- Place more importance on friends
- Feel that no one understands them
- Tryout new behaviors and activities – both healthy and risky
- Understand complicated concepts instead of just the here and now

YOUR TEEN STILL NEEDS YOU TO:

- Give them your time
- Give them a sense of connection or belonging
- Support them
- Provide for their basic needs
- Guide them
- Express your love
- Set limits
- Pay attention to their successes and behaviors
- Be involved and aware of what is going on in their lives

REMEMBER:

All of these changes are perfectly normal! Your teen still needs you, but may not always know how to communicate that. You are still the best person to guide your teen, and it is important to keep talking with them.

Talk to your teen's doctor or nurse about these changes and any challenges you may have with your teen.

WEBSITES FOR PARENTS:

RESOURCES

Children Now and Kaiser Family Foundation
http://www.talkingwithkids.org

Advocates for Youth
http://www.advocatesforyouth.org/

SIECUS– Families are Talking
http://www.familiesaretalking.org

California Family Health Council–Talk with Your Kids
http://www.talkwithyourkids.org/

US Department of Health & Human Services– Parents Speak Up
http://www.4parents.gov/

Nickelodeon–Parents Connect
http://www.parentsconnect.com

TALKING TO YOUR TEEN ABOUT TOUGH ISSUES

The natural changes that happen during the teen years can be hard for you and your teen. In many families, there may be disagreements as teens want more privacy and independence. Parents might feel that their teens are moody and disrespectful.

Teens make decisions about things like sex, smoking, alcohol and drugs. As an adult, you continue to make decisions about these things, too. As the parent of a teen, you have the opportunity and responsibility to help them learn how to make healthy decisions. Teens want information and a close relationship with their parents. Even though it can be hard, it is important to talk openly and often with your teen about these issues.

Tips for talking with your teen:

Talk:	Don't be afraid to talk about tough subjects like sex and drugs. Even if your child is only 10 or 11 years old, you can talk about puberty, peer pressure, and staying healthy. This will let your teen know that it is ok to talk with you about these issues.
Listen:	It is important to listen and be open to your teen's opinions. Try not to interrupt while they are telling you their point of view.
Be honest:	Give truthful answers when your teen asks for information. Don't worry if you don't have all the answers.
Share your ideas and opinions:	Teens want to hear about your values and beliefs.
Respect their opinions:	Teens become more mature and independent, and letting them make their own choices is an important part of growing up. Ask them for their ideas and opinions. Make sure to let them know you are always there to help, even if you do not agree with all of their decisions or behaviors.
Stay calm:	Try to stay calm if they come to you with a problem that is upsetting, so they will not be afraid to talk to you.
Keep talking:	Bring up subjects over and over again. Don't be afraid to bring up important topics that you have already talked about. Use movies, TV shows or news stories about teen health as a way to start discussions.

Don't be afraid to ask for help!

P PARENT

HELPING YOUR TEEN TAKE RESPONSIBILITY FOR THEIR HEALTH

Raising teens can be tough. Sometimes they want you around and sometimes they don't. Sometimes they are responsible and sometimes they are not. Teens need involved parents, but they also need some privacy when it comes to their health. With privacy, they can talk openly to their doctor about their concerns. Without privacy they may avoid going for certain services. These may be called "confidential" or "sensitive" services.

For most types of medical care, parents need to give consent and they can get information about their teen's doctor's visits. But under California law teens can get private care without parent consent for some "confidential" or "sensitive" visits, such as those for:

- Birth control
- Pregnancy
- Sexually transmitted diseases (for ages 12 and older)
- Sexual assault services
- Mental health counseling (for ages 12 and older)
- Alcohol and drug counseling (for ages 12 and older)

Don't I have a right to know what medical care my teen is getting?
Why can my teen go to the doctor for these serious issues without me knowing about it?

Every state has laws for children under 18 to get certain kinds of health care without their parents' consent. Fortunately, MOST teens DO talk to their parents, and they want their parents' advice. You play an important role in helping them stay healthy! But even if the relationship between you and your teen is strong, there are some issues that your teen may want to get care for on his or her own. Teens may be embarrassed, ashamed, or scared to talk to parents about some issues. They may not go to the doctor unless they know the information would be kept private.

What will happen if my child is in danger?

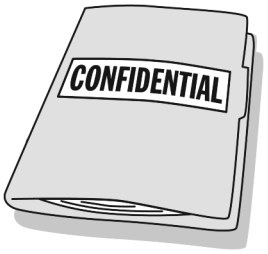
There are some limits to confidentiality. If a doctor or nurse learns that a teen under 18 years is being abused, or is thinking about hurting him/her self or others, the proper authorities must be contacted for help.

Will my teen keep secrets from me since they can get confidential services?

Wanting privacy is a healthy and normal part of growing up. Even though teens are able to get some medical care without parent permission, doctors and nurses encourage them to talk to their parents or another trusted adult.

How can I let my teen know I want to talk to them about these kinds of issues?

As the parent of a teen, part of your job is helping them learn how to make healthy decisions. They are becoming more independent, and making their own choices is an important part of growing up. Make sure you let them know you are always there to help, even if you do not agree with all their decisions. Listen, and when possible, stay calm if they come to you with a problem that is upsetting, so they will continue to talk to you.



KNOW MYSELF, KNOW MY TEEN

Sometimes your opinions can stand in the way of listening to your teen with an open mind. If teens feel judged by their parents or guardians, they are less likely to share information that may be sensitive, embarrassing, or hard to talk about. Ask yourself these questions before you talk about sensitive issues with your teen.

How do I feel?

What is your mood? What are the memories that may shape your opinions? Keep in mind that what you went through as a teen may be different from what your teen is going through now.

What was I doing when I was 16?

Have you thought about what you want to share with your teen? Hold off on sharing sensitive information with your teen until he/she is in the middle teen years.

Are we finding some time together to enjoy each other?

It may be hard to believe, but most teens say they wish they had more time with their parents. Difficult topics may be easier to talk about when you spend enjoyable times together like going for walks, watching movies, doing projects, or sharing meals.

Am I listening to my teen?

Spend as much time listening as you do talking. Avoid making quick judgments. If you do not understand what your teen is trying to say, repeat what they have said back to them.

Do I judge too quickly?

Always ask your teen what she or he is doing rather than thinking the worst. Trust that he or she can make good decisions.

What are my rules about safety?

Tell your teen which rules must be followed for his or her safety. Follow through with consequences if your teen behaves in unsafe ways. Talk about the importance of safety on a regular basis, not only once. Get help immediately if your teen is in an unsafe situation.

Am I willing to get help for any problems I may have?

It is important to be an example for your teen. Seeing family members get help will encourage your teen to get help for his or her own problems.

Adapted with permission from "Are you An Askable Parent?" Advocates for Youth, Washington, DC. www.advocatesforyouth.org

THE 5 BASICS OF HOW TO PARENT TEENS

1. LOVE AND CONNECT

Support and accept your teen as she/he gets older. Their world is changing. Make sure your love doesn't.

Tips for Parents:
- Say good things about your teen when he or she does something well.
- Support your teen's interests, strengths, and talents.
- Spend time one-on-one and as a family.
- Get to know your teen's friends and their parents/caregivers.

2. WATCH AND OBSERVE

Find out what is going on by talking with your teen. Notice your teen's activities.Your interest matters to them.

Tips for Parents:
- Talk with the other adults in your teen's life.
- Be aware of your teen's classes, grades, job, and interests.
- Know where your teen is, what he or she is doing, and who your teen is with.

3. TEACH AND LIMIT

Limits protect your teen from unsafe situations and give him/her room to mature. Be firm, but also be willing to adapt and change your mind.

Tips for parents:
- Help teens make better choices by teaching them instead of punishing them.
- Stand firm on important issues such as safety, and let go of smaller issues.
- Be consistent and follow through with consequences you set up with your teen.
- Be firm about rules without turning to physical punishment.
- Give your teen more responsibility and more freedom to make their own choices as they grow into adults.

4. SHOW AND DISCUSS

Talk to your teen, support him or her, and teach by example!

Tips for Parents:
- Set a good example by behaving the way you want your teen to behave.
- Praise your teen's positive behaviors and habits.
- Give teens the chance to solve their own problems and make their own choices.

5. PROVIDE AND PROMOTE

Teens need parents to give them healthy food, clothing, shelter, and health care.
They also need a caring home and loving adults in their lives.

Tips for Parents:
- Seek out good opportunities and activities for your teen.
- Make sure your teen gets checkups with his/her doctor every year, and any counseling that he or she needs.
- Reach out for support from other parents when you need it!

RESOURCES

Children Now and Kaiser Family Foundation
http://www.talkingwithkids.org

Advocates for Youth
http://www.advocatesforyouth.org/

SIECUS– Families are Talking
http://www.familiesaretalking.org

California Family Health Council–Talk with Your Kids
http://www.talkwithyourkids.org/

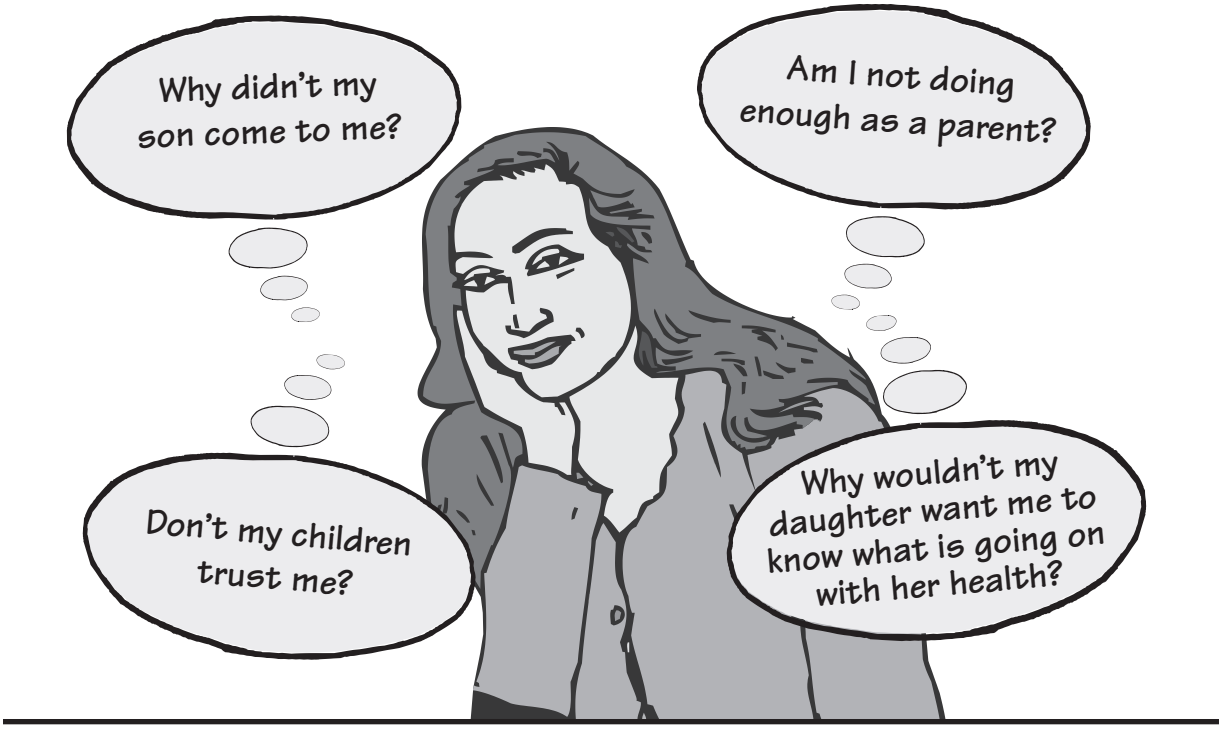
US Department of Health & Human Services–Parents Speak Up
http://www.4parents.gov/

Nickelodeon–Parents Connect
http://www.parentsconnect.com

Adapted with permission from: Simpson AR. Raising Teens: A Synthesis of Research and a Foundation for Action. Center for Health Communication, Harvard School of Public Health. 2001, http://hrweb.mit.edu/worklife/rpteens.html

PARENT

MY TEEN IS GOING TO THE DOCTOR AND NOT TELLING ME!



You just found out that your teen is getting medical services without telling you. As a parent you may be worried and upset when this happens. This is normal. But try thinking about it this way – your teen is being responsible for <u>their</u> health. This is something you can be proud of!

Remember:

- Your teen is becoming more independent. As teens get older they try out more adult behaviors, and may want to find help on their own. This is an important part of growing up.
- You are important to your teen and their health! But even when teens and parents have strong relationships, there are some issues that your teen may want to talk to their doctor about on their own.
- It is never too late to talk to your teen about tough subjects. Start by talking about your own values and expectations. It is important that you:
  - ✔ Stay calm
  - ✔ Listen
  - ✔ Respect <u>their</u> ideas
  - ✔ Share your thoughts and opinions
  - ✔ Do not lecture
- Doctors and nurses want to help and support you. Ask them for help if you have concerns or questions about your teen.

WHAT IS THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)?

The confidentiality rules described in other parts of this toolkit module apply when health and mental health services are provided in a traditional clinical setting. When services are provided on school grounds, however, there are additional federal and state laws that must be considered. One of the most important is the federal Family Educational Rights and Privacy Act (FERPA) and related state education law.

What is FERPA?

The Family Educational Rights and Privacy Act (FERPA) protects the privacy of students' personal information held by "educational agencies or institutions" that receive federal funds under programs administered by the U.S. Secretary of Education.

What is an educational agency or institution subject to FERPA?

"Educational agencies or institutions" are defined as institutions that provide direct instruction to students, such as schools; as well as educational agencies that direct or control schools, including school districts and state education departments.[1] Organizations and individuals that contract with or consult for an educational agency also may be subject to FERPA if certain conditions are met.[2] Almost all public schools and public school districts receive some form of federal education funding and must comply with FERPA.

What information does FERPA protect?

FERPA controls disclosure of written information maintained in the "education record." "Education records" are defined as written records, files, documents, or other materials that contain information directly related to a student and are maintained by an educational agency or institution, or a person acting for such agency or institution.[3] "Information directly related to a student" means any information "that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community…to identify the student with reasonable certainty."[4] Student health records maintained by a school nurse are "education records," as are immunization records housed in a student education file.[5] Oral communications and "personal records,"[6] as that is defined in FERPA, are not considered part of an education record. Personal records are notes kept in the maker's possession, used only as a memory aid, and not shared with anyone except a temporary substitute.

What are the general requirements of FERPA?

Generally, FERPA prohibits educational agencies from releasing any information in the education record unless they have written permission for the release. In most cases, a parent must sign that release. When students are eighteen years old or older, they sign their own release forms. FERPA also requires educational agencies to allow parents to access their minor children's education records.

There are exceptions to these rules, including exceptions that allow agencies and schools to disclose information without a written release in some circumstances. For example, schools may share "directory information"[7] about students with the public if the school and district have first followed certain procedures defined in FERPA, including giving parents an opportunity to opt out. Another exception allows school staff to share information with "school officials"[8] in the same school who have a

"legitimate educational interest" in the information.[9] Certain policies must be in place at the district level in order to implement both exceptions. Additional exceptions also exist, including exceptions that allow sharing information in emergency situations and for school transfers, among others.[10]

Does California have state laws on this issue?

California has state laws that protect the confidentiality of information held by schools.[11] For the most part, the rules and exceptions in California law parallel those found in FERPA.[12]

i 34 C.F.R. § 99.1(a).

ii See e.g. 34 C.F.R. § 99.31(a)(1)(i)(B)("A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official under this paragraph provided that the outside party-- (1) Performs an institutional service or function for which the agency or institution would otherwise use employees; (2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and (3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.").

iii 20 U.S.C. § 1232g (a)(4)(A)("… the term "education records" means, except as may be provided otherwise in subparagraph (B), those records, files, documents, and other materials which—(i) contain information directly related to a student; and (ii) are maintained by an educational agency or institution or by a person acting for such agency or institution.").

iv 34 C.F.R. § 99.3.

v U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, November 2008, [hereinafter Joint Guidance], at page 2.

vi 34 C.F.R. § 99.3 ("'Education Records'... (b) The term does not include: (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.").

viiThe scope of the term 'directory information' will depend on district policy, but can include the following: the student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended by the student. 20 U.S.C. §1232g(a)(5)(A); Cal. Educ. Code §§ 49073; 49061(c).

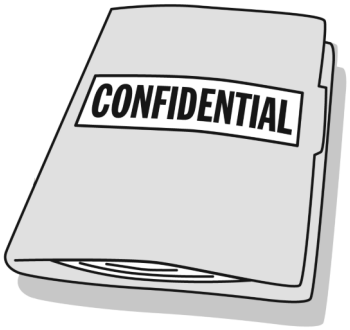
viii The term "school official" includes school staff, such as teachers, counselors, and school nurses. A school or district may define this term more broadly in its School Board Policies so that it also includes outside consultants, contractors or volunteers to whom a school has outsourced a school function if certain conditions are met. See 34 C.F.R. § 99.31(a)(1)(i).

ix 20 U.S.C. §1232g (b)(1) : 34 C.F.R. § 99.31(a)(1)(i)(A).

x See 34 C.F.R §§ 99.31.

xi Cal. Civ. Code §§ 56-56.37; Cal. Welf. & Inst. Code §§ 5328-5329.

xii Cal. Ed. Code § 49060-49079.



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HOW DOES FERPA DIFFER FROM HIPAA?

See pg.47 for HIPAA Overview See page 34 for FERPA overview.

In many ways, the two federal laws are similar.

- Both protect the privacy of personal information.
- Both require a signed authorization before records can be released.
- Both allow sharing of information with certain individuals and agencies without a signed release in certain situations.

Where FERPA and HIPAA differ is in the details. Here are just a few examples of those differences.

- **Signature for Release of Records**
  Under FERPA, a parent must sign the release on behalf of his or her minor child.[1] Under HIPAA, a parent must sign for a minor in most cases; however the minor must sign if the records have to do with health care services for which the minor consented or could have consented under state law.

- **Parent access to records**
  Parents have a right to access all records subject to FERPA regarding their minor child.[2] By contrast, parents do not have a right to access all medical records subject to HIPAA regarding their minor child.[3] For example, parents cannot access those records if a provider determines that parent access 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," or if the records relate to health care for which the minor consented or could have consented on his or her own.[4] In the latter situation, parents must have the minor's permission in order to inspect medical records.[5] This distinction is particularly important to consider if a school health program is going to provide any "minor consent" services, such as reproductive health care, drug or alcohol abuse counseling, or mental health counseling, on the school site.

- **Exchange of Information without a signed consent**
  A school health provider whose records are subject to FERPA, such as a school nurse or counselor, can share information with any school staff who have a "legitimate educational interest" in the information. This facilitates collaboration and communication with non-health personnel at the school, such as teachers and multidisciplinary teams. By contrast, a school health provider whose records are subject to HIPAA cannot disclose medical information to school staff who are not themselves health professionals unless there is a signed release form.

  A school health provider operating under HIPAA may disclose information to any other health provider working with a student for purposes of treatment or referral, including professionals operating in and outside the school, without need of a signed release. A school health provider operating under FERPA cannot. This creates opportunities for referral and collaboration with the community at large that would be impossible under FERPA without a signed release.

Both laws also contain exceptions that allow disclosures for the purpose of research and in health emergencies, but each law defines these situations differently in a way that could impact how a school-based health program sets up its protocols. For example, under both FERPA and HIPAA, providers may disclose protected information when a youth is in danger, but to whom the provider may disclose that information varies under each law. (See section FAQs on Sharing Information pg.40 for more information.)

KEY POINTS about FERPA, HIPAA, and California Law:

Basics

- FERPA and HIPAA can never apply to the same records at the same time.
- FERPA and California medical confidentiality law can apply to the same records at the same time.
- HIPAA or FERPA may apply to control release of health records regarding services provided on a school campus.

FERPA or HIPAA?

- A school health program's records are subject to FERPA if the program is funded, administered and operated by or on behalf of a school or educational institution.
- A school health program's records are subject to HIPAA if the program is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency or individual.

Why does the distinction between FERPA and HIPAA matter?

A few examples:

- A parent's right to access health records is different under HIPAA and FERPA.
- The individuals and agencies with whom a school health provider can exchange health information without a release differ under HIPAA and FERPA.
- The administrative rules, including requirements for consent forms, are different.

i 20 U.S.C. § 1232g(b)(1).
ii 20 U.S.C. § 1232g(a)(1)(A).
iii See Gudeman, *"Minor Consent, Confidentiality and Child Abuse Reporting in California"* for detailed legal information on HIPAA and state medical confidentiality law, available at www.TeenHealthRights.org
iv Cal. Health & Saf. Code § 123115(a).
v See Gudeman, *"Minor Consent, Confidentiality and Child Abuse Reporting in California"* for detailed legal information on HIPAA and state medical confidentiality law, available at www.TeenHealthRights.org

What do I follow: HIPAA, FERPA or CALIFORNIA LAW?

Is it possible to operate under FERPA and HIPAA at the same time?

No. HIPAA explicitly states that its rules do not apply to health information held in an education record subject to FERPA.[1] Therefore, if FERPA applies, HIPAA does not. However, state medical confidentiality law does not have this same exception. Therefore, state medical confidentiality law can apply to health information held in an education record subject to FERPA.

Does FERPA or HIPAA or state law apply to the records of a district employed health provider, such as a school nurse or school mental health clinician?

Student health records maintained by a school nurse or by a licensed psychologist or counselor employed by the school typically are part of the education record subject to FERPA. In addition, California medical confidentiality law also may apply to health information held by a school nurse or psychologist, and in some cases, HIPAA.

Education records are covered by FERPA. In general, a school nurse's or clinician's records become part of the school's education record, as they contain information related to a student and are records maintained by a school employee or agent.[2] These records are not covered by HIPAA because HIPAA specifically states that it does not protect health information in an education record covered by FERPA. However, HIPAA may still apply to some information held by the nurse. Information held by the school nurse or counselor but not placed in the education record, such as health information in oral form or in personal notes, is not covered by FERPA and thus may be protected by HIPAA.

California medical confidentiality law also applies to the nurse's and psychologist's records, even those held in the education file. If FERPA and California law conflict regarding disclosure or protection, providers should seek guidance from their legal counsel about how to proceed.

Does FERPA or HIPAA apply to the records of a school-based health center (SBHC) or outside provider delivering services on school grounds?

It depends. Whether a school health program or provider is subject to HIPAA or FERPA will depend on the relationship between the school-based provider and the educational agency.

HIPAA Applies If: The U.S. Department of Education has said that the records of a SBHC are not subject to FERPA "if the center is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency or individual…."[3] "In these circumstances, the records are not 'education records' subject to FERPA, even if the services are provided on school grounds, because the party creating and maintaining the records is not acting on behalf of the school."[4] The records of a school based health center (SBHC) would be subject to HIPAA in these cases as long as the SBHC engages in any HIPAA covered transactions. (For example, the SBHC uses a billing service that transmits information electronically). (see page A-45 document in toolkit for more information.)

FERPA Applies If: The health provider's records are considered "education records" subject to FERPA if the school-based health program or provider is funded, administered and operated by or on behalf of a school or educational institution. A school health program's records also will be subject to FERPA if the program is administered by and under the direct control of an educational agency and providing what can be considered "institutional services" – even if those services are funded by a grant from an outside agency.

The federal Department of Education provided this example: "Some schools may receive a grant from a foundation or government agency to hire a nurse. Notwithstanding the source of the funding, if the nurse is hired as a school official (or a contractor), the records maintained by the nurse or clinic are 'education records' subject to FERPA."[5]

In these cases, HIPAA would not apply. School-based health providers operating under FERPA, however, should remember that even if their records are not subject to HIPAA, in California, state confidentiality law nevertheless still may apply to their medical records. In some situations, federal FERPA rules and state confidentiality law may conflict. School-based health providers should seek advice from legal counsel should that occur.

If the relationship between the school health provider and the educational institution falls somewhere in between the scenarios presented above, the provider agency and educational institution should seek advice from their respective legal counsel on whether the records of the health program and its staff are subject to FERPA or HIPAA.

Is it possible for a school to contract with a provider and bring the provider under the auspices of FERPA?

FERPA says: "A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official [and therefore subject to FERPA]…provided that the outside party:

(1) Performs an institutional service or function for which the agency or institution would otherwise use employees;

(2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and

(3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records."[6]

i 45 C.F.R. § 160.103("Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g; ….").
ii 20 U.S.C. § 1232g(a)(4)(A).
iii U.S. Dept. of Educ., Family Policy Compliance Office, Letter to Ms. Melanie P. Baise, University of New Mexico, November 29, 2004, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html
iv U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, November 2008, [hereinafter Joint Guidance] at page 5.v Joint Guidance at page 4.
vi 34 C.F.R. § 99.31(a)(1)(i)(B).

FAQs: Exchanging Information between Schools, Health Providers, and School Based Programs

1. **May a school or district share information from the education record, such as schedule, attendance, discipline records or grades, with a school health provider for purposes of service provision?**

   FERPA: Yes, if the school health provider is a school employee or otherwise subject to FERPA. FERPA permits disclosure of information in the education record to other school officials with a legitimate educational interest in the information without need of parent consent.[1] Before exercising this disclosure option, schools must assure that the required annual notice to parents defines school official and legitimate educational interest in a way that would cover this type of disclosure to a school health program. The school health program will be required to protect the information by following FERPA requirements.[2]

   HIPAA: For the most part, no, not without parent consent if the provider is subject to HIPAA. A school employee operating under FERPA may not provide detailed information from the education record to a non-FERPA provider without parent consent, though the school could release certain limited information. For example, the school could give the provider access to directory information about a specific student without needing parent consent. What that would include will depend on how directory information has been defined by that school district in its annual notice to parents and whether parents have opted out. In addition, the school also may disclose to the provider information that is not contained in the education record, such as information from oral communications or personal observation.[3]

2. **May a school share information from the education record with a health provider if it is a health emergency?**

   Yes, any school employee may disclose information contained in the education record with appropriate parties in an emergency, without needing parent consent. However, the definition of emergency is strictly limited under FERPA. The U.S. Department of Education interprets emergency to be "a specific situation that presents imminent danger" or requires an immediate need for information to avert a serious threat. The emergency situation must be evaluated on an individual basis.[4]

3. **May a school or district disclose information to an outside contractor or co-located program/service?**

   Yes, as long as the contractor or program is subject to FERPA. According to guidance from the U.S. Department of Education, "agencies and institutions subject to FERPA are not precluded from disclosing education records to parties to whom they have outsourced services so long as they do so under the same conditions applicable to school officials who are actually employed." The guidance reminds districts that "an educational agency or institution may not disclose education records without prior written consent merely because it has entered into a contract or agreement with an outside party. Rather, the agency or institution must be able to show that:
   1) The outside party provides a service for the agency or institution that it would otherwise provide for itself using employees;
   2) The outside party would have "legitimate educational interests" in the information disclosed if the service were performed by employees; and
   3) The outside party is under the direct control of the educational agency or institution with respect to the use and maintenance of information from educational records."

   The guidance reminds districts that they remain completely responsible for their contractor's compliance with FERPA requirements in these situations and states "[f]or that reason, we recommend that these specific protections be incorporated into any contract or agreement between an educational agency or institution and any non-employees it retains to provide institutional services."[5]

4. May a school or district share information from the education record about chronic disease, such as asthma and diabetes, with a health provider operating under HIPAA?

Yes, but only with a signed release or in an emergency. Disclosure of information in the education file about a student's chronic conditions to a school-based provider operating under HIPAA is not permitted without parent consent. Information from the education record may be disclosed without parent consent to protect the health or safety of a student or other individual.[6] However, this exception has been strictly interpreted by the U.S. Department of Education. The emergency must be a specific situation that requires immediate need for disclosure of the information. For example, the emergency exception could not be used to send a list of all students with asthma or diabetes to the school-based health center. The school could provide the information about a specific student having a health emergency, including acute symptoms of asthma or diabetes.

5. May a school health program or provider disclose health information to school staff? For example, may a provider let a teacher know how a student is progressing in treatment?

FERPA: If the program or provider operates under FERPA, the program or provider may share health information in the education record with the teacher to the extent that the teacher has a "legitimate educational interest," as that term is defined by the district, in the information disclosed.[7]

HIPAA: If the health provider or program operates under HIPAA, the provider can share if there is a signed release allowing the disclosure. If there is no release, the provider cannot. There is no exception under HIPAA that would allow a school health program to share protected health information with a teacher without an authorization. The student must provide the authorization if the information to be disclosed is about a minor consent service. The parent or guardian must provide the authorization in most other cases.

6 May a therapist disclose information obtained in the course of counseling a student on the school campus, regarding the student's threat to commit suicide?

Yes, FERPA, HIPAA, and state law all permit such disclosure without consent under certain "dangerous" conditions. If the therapist operates under FERPA, the therapist may disclose written education records to "appropriate parties" if the therapist reasonably determines that the student's statements indicate a serious and imminent threat to the student's health or safety.[8]

If the therapist operates under HIPAA, the therapist may disclose the relevant information to any person who is reasonably able to prevent a serious or imminent threat to the health or safety of a person.[9] Therapists are even permitted to disclose psychotherapy notes without authorization under emergency circumstances.[10]

Under California law, a therapist may disclose medical information as necessary to prevent or lessen a threat to the health or safety of a reasonably foreseeable victim or victims. Exactly when and to whom such information can be disclosed will depend on which California law the therapist is providing services under. For example, if the therapist is subject to the Civil Code, disclosure of information may be to any person reasonably able to prevent or lessen the threat, including the target of the threat.[11] Therapists should consult their own legal counsel for more information and guidance on which California confidentiality law applies to their records.

7. May a school health program operating under FERPA promise students that their parents will not have access to their "minor consent" health records?

For the most part, no. The records of school health providers and programs operating under FERPA are part of the education record, and under FERPA, parents have a right to inspect the education record of their child if they choose to

do so.[12] There is no exception under FERPA that limits parent inspection rights simply because the information in the record pertains to health care services, or to "minor consent" services, with one caveat: Parents usually do not have the right to inspect health information in the education record of students eighteen and older, though there are exceptions to this rule as well.[13]

While parents cannot be prevented from viewing "minor consent" health information in the education record under FERPA, FERPA contains no affirmative obligation that requires schools to inform parents about "minor consent" health care services that a student may have received. Further, FERPA only allows parents a right to inspect "education records." To the extent school health services providers hold information about minor consent services that is not recorded in the education record, (such as information in oral form or personal notes), the information would not be subject to FERPA.

It should be noted that this answer does not take into account state medical confidentiality law, which may apply to the same records at the same time as FERPA. Obligations under FERPA and state medical confidentiality law regarding parent access to minor consent records can conflict at times. Providers should seek guidance from their own legal counsel.

8. May a school health provider operating under HIPAA disclose protected health information to the school nurse or school therapist?

In most cases, yes. HIPAA and California law permit disclosures to other health care providers for "treatment" purposes. "Treatment" is defined broadly in this context and includes coordination or management of health care, consultation and referral as well as direct treatment.[14] It is important to note that once disclosed to the school nurse, if the school nurse places the information in the pupil file, FERPA will apply when determining who controls access to the information in the file, not HIPAA.[15]

i 20 U.S.C. § 1232g(b)(1).
ii 34 C.F.R. § 99.33(a)(1).
iii 34 C.F.R. § 99.3 ("'Education Records'... (b) The term does not include: (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.").
iv U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html.
v U.S. Dept. of Educ., Family Policy Compliance Office, "Letter to Clark County School District (NV) re: Disclosure of Education Records to Outside Service Providers," June 28, 2006, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/clarkcty062806.html
vi U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html.
vii 20 USC § 1232g(b)(1).
viii 34 C.F.R. §§ 99.31(a)(10)& 99.36(a); U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html.
ix 45 C.F.R. §164.512(j).
x 45 C.F.R. § 164.508 (a)(2)(ii); 45 C.F.R. § 164.501.
xi Cal. Civ. Code § 56.10 (c)(19)("The information may be disclosed, consistent with applicable law and standards of ethical conduct, by a psychotherapist, as defined in Section 1010 of the Evidence Code, if the psychotherapist, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.").
xii 34 C.F.R. § 99.10.
xiii 34 C.F.R. § 99.5.
xiv45 C.F.R. § 164.501.
xv U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, November 2008, at page 2.

CONFIDENTIALITY LITERATURE REVIEW SUMMARIES

1. **Council on Scientific Affairs, American Medical Association 1993, "Confidential health services for adolescents," Journal of the American Medical Association, vol. 269, no. 11, pp. 1420-1424.**

   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. 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, C.A., Millstein, S.G., Halpern-Felsher, B.L. & Irwin, C.E., Jr 1997, "Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care," Journal of the American Medical Association, vol. 278, no. 12, pp. 1029-1034.**

   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. 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.

3. **National Association of School Nurses 2004, "Privacy Standards for Student Health Records." Available: www.nasn.org/Default.aspx?tabid=277.**

   School-Based Health Centers and other on-campus health services for students need more sufficient policies, procedures, and systems to ensure the privacy of students' health information. This article outlines the complications caused by both HIPAA and FERPA with regards to school health records, and outlines the role of school nurses in promoting privacy of student health information. School nurses should educate themselves, administrators, students, and parents about health record laws. School nurses should ensure that health room procedures are conducive to maintaining health record privacy. School nurses should act as experts, collaborating with the other professionals around them to help develop supportive policies for privacy of students' health information.

4. **English, A. & Ford, C.A. 2007, "More evidence supports the need to protect confidentiality in adolescent health care," Journal of Adolescent Health, vol. 40, no. 3, pp. 199-200.**

   This editorial article outlines and summarizes some of the recent research that further supports the need for confidentiality in adolescent health care, and includes 20 references to the most important research on adolescent health care and confidentiality.

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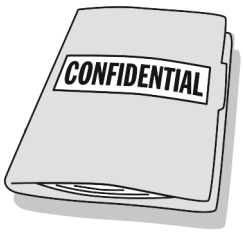

5. **Fox, H.B. & Limb, S.J. 2008, "Fact Sheet 5: State Policies Affecting the Assurance of Confidential Care for Adolescents" [Homepage of The National Alliance to Advance Adolescent Health], [Online]. Available: http://www.thenationalalliance.org/jan07/factsheet5.pdf.**

   This fact sheet outlines state policies that aim to provide adolescents with certain confidential care, and how that confidentiality can be breached by public and private insurance practices such as sending explanation of benefit statements (EOBs) to the patient's household. EOBs are an inexpensive way to comply with federal verification laws to combat fraud, but insurance companies can comply with the law in other ways that do not breach confidentiality. Furthermore, states can exclude sending EOBs for certain services, so they should exclude all family planning, STD, mental health, and substance abuse treatment services.

6. **Brown, J.D. & Wissow, L.S. 2009, "Discussion of sensitive health topics with youth during primary care visits: relationship to youth perceptions of care," Journal of Adolescent Health, vol. 44, no. 1, pp. 48-54.**

   This study examined whether the discussion of sensitive health topics such as sex, drugs, and mental health during primary care visits was associated with youth perceptions of care. Youth age 11-16 reported directly after a primary care visit whether the visit included discussion about sensitive health topics, and whether the provider understood their problems, eased their worries, allowed them to make decisions about treatment, gave them some control over treatment, and asked them to take some responsibility for treatment. The researchers found that youth has more positive perceptions of the provider and were more likely to report taking an active role in treatment when the visit included the discussion of a sensitive health topic.

7. **Ford, C.A., Davenport, A.F., Meier, A. & McRee, A.L. 2009, "Parents and health care professionals working together to improve adolescent health: the perspectives of parents," Journal of Adolescent Health, vol. 44, no. 2, pp. 191-194.**

   Investigators explored parent perceptions of the roles of parents, health care providers (HCPs), and parent-HCP partnerships in improving adolescent health and health care. When asked what parents can do to keep teens healthy, the most common themes reported were keeping teens busy, parental monitoring, and parent-teen communication. When asked what HCPs can do to keep teens healthy, the most common theme was teens being able to openly communicate with HCPs so that HCPs can accurately assess the teen's health and behaviors. New ideas for improving parent-HCP partnerships emerged, including HCPs acknowledging the importance of normal parenting activities, HCPs assisting parents in recognizing when to ask for help (and encouraging parental acceptance of help when offered), and further investigation of the benefits of improved parent-HCP communication.

8. **Guttmacher Institute 2010, February 1st 2010-last update, "State Policies in Brief: An Overview of Minors' Consent Law" Available: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf.**

   Many states explicitly permit minors to consent to services for sexual and reproductive health care, including contraceptives, prenatal, and STI services without parental involvement. Conversely, parental involvement in a minor's abortion is required in the majority of states. This overview of Minors' Consent Law across the United States includes a chart outlining each state and what services minors can consent to in that state out of contraceptive services, STI services, prenatal care, adoption, medical care for minor's child, and abortion services.

FEDERAL MEDICAL PRIVACY REGULATIONS ("HIPAA PRIVACY RULE"): A BRIEF OVERVIEW

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 Privacy Rule") that broadly regulate access to and disclosure of confidential medical information. This summary provides a brief introduction to the provisions pertinent to adolescents, particularly those who are minors. Detailed information regarding those provisions and information regarding other provisions of the regulations is available from other sources.

How do the federal privacy regulations relate to state law?

The HIPPA Privacy Rule generally requires a uniform minimum standard of confidentiality protection. Federal privacy regulations under HIPAA supersede – or "preempt" – state laws, but with two important exceptions: state laws that are more stringent – i.e. more protective of individual privacy – are controlling; and on the question of parents' access to their children's protected health information, HIPAA defers to state and other applicable laws.

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 rights for individuals to have access to their health information and medical records and 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 insurance plans (including Medi-Cal and CHIP – Healthy Families in California), 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 are required to comply with the regulations.

What do the regulations mean for adolescents?

The HIPAA Privacy Rule contains numerous general provisions that affect the confidentiality of information about health care provided to adolescents as well as younger children and adults. The regulations also contain some provisions of particular relevance and importance for adolescents. Adolescents who are age 18 or older are adults and have the same rights under the regulations as other adults. Adolescents who are younger than age 18 are minors and the regulations establish special rules for the confidentiality of their protected health information.

Do adolescents control access to their own health information?

The HIPAA Privacy Rule establishes that when an individual provides consent for health care, that individual has specific rights to control access to the information about that care. Those rights are not absolute and are subject to certain exceptions. For example, an individual's protected health information may be disclosed without the individual's authorization for purposes of treatment, payment, and health care operations. Adolescents who are adults control access to their own health information on the same basis as other adults. However, different rules apply to adolescents who are minors. In particular, in certain situations, such as when minors consent for their own health care, the question of whether their parents have access to the information about the care is determined by state or "other applicable law."

What is the role of parents for adolescents who are minors?

Parents (including guardians and persons acting in loco parentis) generally are considered the personal representatives of their unemancipated minor children, and as such, they have control over and access to their child's protected health information to the extent that the regulations provide individuals generally with such control and access. In specific circumstances, however, 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 and has consented; 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 is treated as the "individual" and may exercise many of the rights under the regulations. 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 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 permits disclosure or is silent on the question, a health care provider has discretion to determine whether 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.

When services are being provided in a school setting, do HIPAA or FERPA Regulations apply?

The interaction of school/healthcare setting regulations is very complex; please refer to our other documents on HIPAA/FERPA in the toolkit for more information.

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. HIPAA serves as a reminder to organizations and health care professionals that adolescents are a group with distinct rights that must be respected. The HIPAA Privacy Rule makes clear that when adolescents have a right to give consent for their own care, organizations must honor their right to be treated as individuals. To understand what is required in any specific case or situation, organizations and health care professionals must consider not only the HIPAA Privacy Rule itself, but also relevant provisions of California laws, and other applicable laws, including other federal laws.

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/.

What are the official citations for the regulations?

Standards for Privacy of Individually Identifiable Health Information,45 Code of Federal Regulations Parts 160 and 164. These regulations were originally promulgated at 65 Federal Register 82461 (Dec. 28, 2000) and Federal Register 53182 (Aug. 14, 2002).

Additional Resources

Office for Civil Rights (OCR).
http://www.hhs.gov/ocr/hipaa

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/privacyrule

National Institutes of Health (NIH)
http://privacyruleandresearch.nih.gov

Based on information provided by:
Center for Adolescent Health & the Law
Chapel Hill, NC
http://www.cahl.org

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/fileadmin/ncyl/youthlaw/publications/minor_consent/Minor_Consent_Report_Download.pdf
CA Minor Consent Laws: Who can consent for what services and providers' obligations
http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/minor_consent/CA_minor_consent_sep03.pdf

Center for Adolescent Health & the Law
http://www.cahl.org/
See Publications relating to Consent & Confidentiality Protections
http://www.cahl.org/consentpubs.htm

Society for Adolescent Medicine
http://www.adolescenthealth.org
See Publications
Confidential Health Care for Adolescents
http://www.adolescenthealth.org/Content/NavigationMenu/Advocacy?PositionPapers/PositionPaper_Confidential_Health_Care_for_Adolescents.pdf

California Hospital Association
http://www.calhospital.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.calhospital.org/public/minors-health-care-law