Understanding Minor Consent and Confidentiality in Colorado

UNDERSTANDING MINOR CONSENT AND CONFIDENTIALITY IN COLORADO

An Adolescent Provider Toolkit

COLORADO ASSOCIATION FOR SCHOOL-BASED HEALTH CARE

COLORADO ASSOCIATION FOR SCHOOL-BASED HEALTH CARE

Adolescent Reproductive Health Toolkit

Dear Colleague,

The Colorado Association for School-Based Health Care (CASBHC) is pleased to present you with the Colorado edition of "Understanding Minor Consent and Confidentiality". This toolkit was originally developed by the Adolescent Health Working Group and the California Adolescent Health Collaborative.

Since 2008, when CASBHC began its work on the Adolescent Reproductive Health Toolkit, school-based health center providers have presented a multitude of questions regarding minor consent and confidentiality. While researching the topics, CASBHC came across the California toolkit, which addressed the very same issues providers in Colorado were asking about.

With permission, the original toolkit has been adapted to include Colorado specific statutes and information. Parts of the toolkit that did not require adaptation have been taken directly from the California toolkit as those tools had already been developed and reviewed by an array of experts. Additional resources were also added to address the many differences in laws between the two states. All the materials were then reviewed by a local committee comprised of doctors, nurse practitioners, and lawyers. The adapted toolkit includes:

- Charts on minor consent and confidentiality
- Practice tools
- Resource sheets
- Health education handouts for teens and their parents/guardians
- Online resources and research
- Legal information
- Information addressing issues of HIPAA and FERPA

The materials included in this toolkit are free to copy and distribute to your adolescent patients and their families or to hang in waiting and exam rooms. This information applies not only to teens utilizing school-based health centers, but to teens accessing services in a variety of medical settings.

Please note, this document is intended only for use as a reference. It is not legal advice. Legal counsel should be consulted for additional information. If you have questions regarding the toolkit or the included resources, please call the Colorado Association for School-Based Health Care at 303-399-6380.

Sincerely,

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Colorado Association for School Based Health Care

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Colorado Minor Consent Laws

This chart describes the medical services that minors in Colorado may obtain on their own consent.

TYPE OF SERVICE: Family Planning, Reproductive Health	LAW / DETAILS

Contraception and Information about Contraception
 	
• See also "Family Planning Services Funded through Title X" below.
	• With the minor's consent, a physician may give birth control procedures, information and supplies to any minor of any age who requests and is in need of them. Colo. Rev. Stat. § 13-22-105. (See statute for complete list of minors who may obtain such care.)
	• Colorado law also states that:
	  • "[a]ll medically acceptable contraceptive procedures, supplies, and information shall be readily and practically available to each person desirous of the same regardless of sex, sexual orientation, race, color, creed, religion, disability, age, income, number of children, marital status, citizenship, national origin, ancestry, or motive." Colo. Rev. Stat. § 25-6-102(1).
	  • "No hospital, clinic, medical center, institution, or pharmacy shall subject any person to any standard or requirement as a prerequisite for any contraceptive procedures, supplies, or information, including sterilization, other than referral to a physician." Colo. Rev. Stat. § 25-6-102(3).
	  • "Dissemination of medically acceptable contraceptive information by duly authorized persons at schools, in state, district, and county health and welfare departments or public health agencies, in medical facilities at institutions of higher education, and at other agencies and instrumentalities of this state is consistent with public policy." Colo. Rev. Stat. § 25-6-102(8).
	• This statute does not allow minors to consent to permanent sterilization on their own accord. Colo. Rev. Stat. § 25-6-102(6).

Prenatal, Delivery, and Post-Delivery Medical Care	A pregnant minor of any age may authorize prenatal, delivery, and post-delivery medical care for herself related to the intended live birth of a child. Colo. Rev. Stat. § 13-22-103.5.
Abortion	A minor of any age may consent for her own abortion services. However, in many circumstances, the provider cannot perform the procedure until 48 hours *after* delivery of written notice to parents or other specified persons. *See* Colo. Rev. Stat. §§ 12-37.5-103 to 105. Notice is not required in all circumstances. There also is a judicial bypass option. The notification requirements, exceptions to notification and judicial bypass process are described in the tool entitled "*Confidentiality of Adolescent Medical Records under Colorado law*" also in this toolkit.

Diagnosis and Treatment for Sexually Transmitted Infections	Upon the minor's consent, a physician may diagnose, prescribe for, and treat a minor of any age for a sexually transmitted infection. Colo. Rev. Stat. § 25-4-402(4).
HIV Testing and Treatment	Upon the minor's consent, qualified medical practitioners and facilities may examine and treat a minor of any age for HIV infection. Colo. Rev. Stat. § 25-4-1405(6).
Family Planning Services Funded through Title X Including, among other services, contraception, STD testing, and breast and pelvic examinations.	Title X funded services must be made available to all minors, regardless of their age, based on the minor's consent. See 42 C.F.R. § 59.5(a)(4). The Title X Family Planning program is part of the federal Public Health Service Act and funds family planning programs nationally. See www.cdphe.state.co.us/pp/womens/famplan.html for more information.
TYPE OF SERVICE: **Services Following Sexual Assault**	**LAW / DETAILS**
Services for Victims of a "Sexual Offense" Sexual offenses are defined in reference to Part 4 of Article 3 of Title 18 of the Colorado Revised Statutes, and they include, among others, the crimes of sexual assault, sexual assault on a child, and unlawful sexual contact.	• When a minor "indicates that he or she was the victim of a sexual offense," a physician may, with the minor's consent, perform customary and necessary examinations to obtain evidence of the sexual offense and may prescribe for and treat the patient for any immediate condition caused by the sexual offense. Colo. Rev. Stat. § 13-22-106(1). • Health care facilities that provide emergency care to sexual assault survivors and are licensed pursuant to Title 25, Article 3, Part 1 of the revised statutes must inform survivors in a timely manner about the availability and use of emergency contraceptives. There are a few situations in which this is not required. Colo. Rev. Stat. § 25-3-110.
TYPE OF SERVICE: **Mental Health, Treatment for Drug or Alcohol Use or Addiction**	**LAW / DETAILS**
Mental Health Treatment Special rules apply to inpatient and electroconvulsive treatment.	A minor who is **fifteen years of age or older** may consent to receive mental health services to be rendered by a facility or a professional person. Colo. Rev. Stat. § 27-65-103(2).
Treatment for Addiction to or Use of Drugs	• With the minor's consent, a physician "may examine, prescribe for, and treat such minor patient for addiction to or use of drugs without the consent of or notification to the parent, parents, or legal guardian of such minor patient, or to any other person having custody or decision-making responsibility with respect to the medical care of such minor patient." Colo. Rev. Stat. § 13-22-102. • "Minors may voluntarily apply for admission to alcohol/other

Treatment for Addiction to or Use of Drugs	drug abuse treatment, **regardless of their age**, with or without parental or legal guardian consent providing the treatment agency demonstrates adherence to its policy regarding admission of minors without parental or legal guardian consent. …Minors' signatures shall suffice to authorize treatment, releases of information, fee payment (if minors have personal control of adequate financial resources), and other documents requiring client signatures. 6 Colo. Code Regs. § 1008-1 (15.225.2)[1] (emphasis added).
Treatment for Alcoholism and Intoxication	• "An alcoholic, including a minor, may apply for voluntary treatment directly to an approved treatment facility." Colo. Rev. Stat. § 27-81-109. • "An intoxicated person or person intoxicated or incapacitated by alcohol, including a minor, may voluntarily admit himself or herself to an approved treatment facility for emergency treatment." Colo. Rev. Stat. § 27-81-110. • "Minors may voluntarily apply for admission to alcohol/other drug abuse treatment, **regardless of their age**, with or without parental or legal guardian consent providing the treatment agency demonstrates adherence to its policy regarding admission of minors without parental or legal guardian consent. … Minors' signatures shall suffice to authorize treatment, releases of information, fee payment (if minors have personal control of adequate financial resources), and other documents requiring client signatures." 6 Colo. Code Regs. § 1008-1 (15.225.2)[2](emphasis added). <u>Definitions</u> • "'Alcoholic' means a person who habitually lacks self-control as to the use of alcoholic beverages or uses alcoholic beverages to the extent that his or her health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Nothing in this subsection (1) shall preclude the denomination of an alcoholic as intoxicated by alcohol or incapacitated by alcohol." Colo. Rev. Stat. § 27-81-102(1). • "'Incapacitated by alcohol' means that a person, as a result of the use of alcohol, is unconscious, has his or her judgment otherwise so impaired that he or she is incapable of realizing and making a rational decision with respect to his or her need for treatment, is unable to take care of his or her basic personal needs or safety, or lacks sufficient understanding or capacity to make or communicate rational decisions about himself or herself."

[1]This regulation applies to programs licensed to treat minors by the Colo. Department of Human Services – Alcohol and Drug Abuse Division. (6 Colo. Code Regs. § 1008-1 (15.210)).

[2]This regulation applies to programs licensed by the Colo. Department of Human Services – Alcohol and Drug Abuse Division. (6 Colo. Code Regs. § 1008-1 (15.210)).

	Colo. Rev. Stat. § 27-81-102(9). • "'Intoxicated person' or 'person intoxicated by alcohol' means a person whose mental or physical functioning is temporarily but substantially impaired as a result of the presence of alcohol in his or her body. Colo. Rev. Stat. § 27-81-102(11). • "'Approved private treatment facility' means a private agency meeting the standards prescribed in section 27-81-106 (1) and approved under section 27-81-106….'Approved public treatment facility' means a treatment agency operating under the direction and control of or approved by the unit or providing treatment under this article through a contract with the unit under section 27-81-105 (7) and meeting the standards prescribed in section 27-81-106 (1) and approved under section 27-81-106." Colo. Rev. Stat. § 27-81-102(2&3).
TYPE OF SERVICE **General Care / Consent Based on Minor's Status**	**LAW / DETAILS**
Minor, 15 Years or Older, Living Separate and Apart, and Managing Own Financial Affairs	A minor **fifteen years of age or older** who is living separate and apart from his or her parent, parents, or legal guardian, with or without the consent of his or her parent, parents, or legal guardian, and is managing his or her own financial affairs, regardless of the source of his or her income may give consent to organ or tissue donation or the furnishing of hospital, medical, dental, emergency health, and surgical care to himself or herself."Colo. Rev. Stat. § 13-22-103(1).
Married Minor	Any minor who has contracted a lawful marriage may give consent to organ or tissue donation or the furnishing of hospital, medical, dental, emergency health, and surgical care to himself or herself. Colo. Rev. Stat. § 13-22-103(1).
Minors in Colorado's Youthful Offender System	• A minor "who has been sentenced to the youthful offender system pursuant to this section" can consent to "hospital, medical, mental health, dental, emergency health, or emergency surgical care" without the consent of a parent or legal guardian. Colo. Rev. Stat. § 18-1.3-407(4.5). • This law applies only to the Youthful Offender System, which is separate from the main juvenile justice system. More information about the Colorado Youthful Offender System can be found on the Colorado Department of Corrections site, at http://www.doc.state.co.us/facility/yos-youthful-offender-system

COLORADO MINOR CONSENT LAWS – Quick Reference Chart[1]	
SERVICES YOUTH CAN OBTAIN ON THEIR OWN	
Family Planning Services Funded by Title X[2] • Includes (among others) contraception, STD testing, and breast and pelvic examinations.	Minors of any age
Prenatal, Delivery, and Post- Delivery Care • Medical care related to the intended live birth of a child.	Pregnant minors of any age
Contraception • Birth control procedures, supplies, and information. • This does not include sterilization	Minors of any age who request and need birth control
Abortion[3]	Minors of any age
Sexually Transmitted Infections • Diagnosis and treatment	Minors of any age
HIV • Diagnosis and treatment	Minors of any age
Treatment after Sexual Offense (Sexual Assault) • Examinations, prescription and treatment of victim for any immediate condition caused by a sexual offense • For this purpose, "sexual offenses" include (but are not limited to) sexual assault, sexual assault on a child and unlawful sexual contact as defined by Colorado law.	Minors of any age
Mental Health Treatment • Includes outpatient treatment • Minors cannot consent to electroconvulsive treatment	Minors 15 years of age or older
Alcohol / Drug Abuse Treatment • Includes treatment for addiction to or use of drugs, emergency treatment for intoxication, and treatment for alcoholism.	Minors of any age

[1] For more information and detail about these laws, see the companion tool entitled "*Colorado Minor Consent Laws*." Remember that consent and confidentiality are different concepts. For more information on confidentiality laws, see the tool entitled "*Confidentiality of Adolescent Medical Records under Colorado Law*."

[2] The Title X Family Planning Program is part of the federal Public Health Services Act. For more information on Title X family planning services and Title X funded providers in Colorado, go to www.cdphe.state.co.us/pp/womens/famplan.html.

[3] A parent is not required to consent to a minor's abortion. However, the minor's parent(s) must be notified 48 hours before the abortion can be performed unless an exception applies or the minor obtains a court order through the judicial bypass process. See the tool entitled "*Confidentiality of Adolescent Medical Records under Colorado Law*" for more information.

CONFIDENTIALITY OF ADOLESCENT MEDICAL INFORMATION UNDER COLORADO LAW

Q: What laws protect the confidentiality of health information in Colorado?

A: Several federal and state laws and regulations protect the confidentiality of health information in Colorado. They apply in different circumstances, depending on the type of health service provided, the funding source for the service, and the type of professional or agency providing the service, among other things. Some have broader application than others.

One law that applies in most contexts is the Privacy Rule created pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA protects the confidentiality of health information held by "covered entities."[1] Most, but not all, health care providers and agencies in Colorado are "covered entities"[2] subject to HIPAA.

Other federal laws and regulations also apply in certain circumstances to protect the confidentiality of certain records. Some examples of these laws are described below in the response to the question "*What laws limit or grant parent access to medical information about minors?*"

Colorado also has state statutes and regulations that apply in specific circumstances to protect the confidentiality of specific records. For example, one Colorado statute limits access to medical information in "public records."[3] Another statute specifically protects the confidentiality of certain behavioral and mental health information.[4]

Health care providers subject to HIPAA must follow both the federal HIPAA Privacy Rule and applicable state law when possible. If the federal and state laws conflict, providers usually must follow the more stringent confidentiality protection, be it in federal or state law.[5]

Q: What is the confidentiality rule under HIPAA?

A: HIPAA limits "covered entities" from disclosing what HIPAA defines as "protected health information"[6] (PHI). A health care provider can only disclose PHI if the provider has a signed authorization allowing for the disclosure, or if there is a specific exception in federal or state law that allows or requires the disclosure.[7]

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[1] 45 C.F.R. Parts 160 and 164.
[2] 45 C.F.R. § 160.103 (" Covered entity means: (1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.").
[3] Colo. Rev. Stat. [hereinafter "C.R.S."] § 24-72-204(3)(a).
[4] *See* C.R.S. § 27-65-121.
[5] 45 C.F.R. § 160.203.
[6] 45 C.F.R. § 160.103 (defining "protected health information," "health information," and "individually identifiable health information"). PHI includes oral communications as well as written or electronically transmitted information, created or received by a health care provider; that relate to the past, present or future physical or mental health or condition of an individual; and either identify the individual or can be used to identify the individual patient.
[7] *See* 45 C.F.R. § 164.502.

Q: What disclosures are permitted under HIPAA without an authorization?

A: HIPAA contains several exceptions that allow or require health care providers to disclose medical information in certain circumstances without need of a written authorization. In all cases, disclosure must be limited to the requirements of the law.[8] Examples of these exceptions include, but are not limited to, the following:

- ***For Treatment, Payment and Health Care Operations***
  HIPAA permits a health care provider to use or disclose protected health care information for treatment, payment and health care operations, as defined by HIPAA.[9] Providers should consult legal counsel for more information, including information regarding the intersection of HIPAA and state law.

- ***Mandated Child Abuse Reporting***
  Colorado's child abuse reporting law requires certain named professionals to make child abuse reports and requires release of certain otherwise protected medical information as part of the report.[10] HIPAA regulations allow health care providers to comply with this law.[11] (For more information on mandated reporting, see the document entitled "*Colorado Mandated Child Abuse Reporting*" in this toolkit).

- ***Reporting Certain Wounds and Injuries***
  State law requires certain licensed health care providers to report certain wounds to law enforcement.[12] HIPAA regulations allow health care providers to comply with this law.[13]

- ***Other Disclosures***
  There are additional exceptions allowing or requiring disclosures, even absent patient or parent authorization. Please see HIPAA and other relevant law and consult legal counsel for more information.

Q: Who may sign an authorization to disclose a minor's medical information under HIPAA?

A: Under HIPAA, a parent or guardian[14] usually must sign an authorization to release health information about their minor child.[15] However, there are exceptions.

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[8] *See* 45 C.F.R. § 164.512(a)(1).
[9] 45 C.F.R. § 164.502(a)(1)(ii); 45 C.F.R. § 164.506(a),(c).
[10] C.R.S. § 19-3-304.
[11] *See* 45 C.F.R. § 164.512. *See* Colo. A.G. Op. No. 03-06 at 6.
[12] C.R.S. § 12-36-135(1)(a)("It shall be the duty of every licensee who attends or treats a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument that the licensee believes to have been intentionally inflicted upon a person, or an injury arising from a dog bite that the licensee believes was inflicted upon a person by a dangerous dog, as defined in section 18-9-204.5 (2) (b), C.R.S., or any other injury that the licensee has reason to believe involves a criminal act, including injuries resulting from domestic violence, to report the injury at once to the police of the city, town, or city and county or the sheriff of the county in which the licensee is located….").
[13] *See* 45 C.F.R. § 164.512; *See* Colo. A.G. Op. No. 03-06 at 3-4.
[14] See HIPAA for definitions of "Parent" and "guardian." Other laws may use slightly different definitions. Legal counsel can provide more information.
[15] 45 C.F.R. §§ 164.502(g)(1); (g)(3); *see* 45 C.F.R. § 164.508(c)(vi).

For example***, if the minor consented for his or her own care, the HIPAA regulations state that the minor must authorize disclosure of the related records.***[16] The minor also must sign the authorization in a few other situations; for example, the minor must sign if a court consented for the minor's medical care pursuant to state law or the parent or guardian assented to an agreement of confidentiality.[17]

Other laws and regulations contain different rules regarding who must sign an authorization to release records, and these rules may apply depending on the type of service provided or the funding source for the service, among other things. For example, if the records relate to services funded under the federal Title X family planning program, the minor patient must sign any authorization to release medical information.[18] Similarly, if the records relate to individuals in substance abuse treatment and are subject to the federal regulations protecting such records, then the minor patient must sign any authorization to release the information.[19]

Q: May parents access information regarding health services provided to their children?

A: Under HIPAA, parents and guardians generally have a right to inspect their minor children's records.[20]

When a minor consents for his or her own care, the HIPAA regulations state that only the minor can sign to release the related records. However, HIPAA treats parents and parent access differently.

When a minor consents for his or her own health care, the HIPAA regulations state that a parent or guardian's right to inspect the related medical records is determined by state and federal law, not HIPAA.[21] The federal and Colorado state laws that specifically *limit* or *grant* parental access to a child's "minor consent" records are discussed in the answer to the following question.

If there is nothing in any other law, including case law, specifying whether or not a parent may have access to the information, the HIPAA regulations state that a health care provider may decide to provide or deny access to a parent or guardian as long as that decision is consistent with state or local law, and the decision is made by a licensed health care professional exercising his or her professional judgment.[22] Providers should consult legal counsel for more information about application of this rule.

Q: What laws may limit or grant parent access to medical information about minors?

A:

Laws Limiting Parental Access to a Minor's Medical Record Based on Risk To Minor Patient:

[16] 45 C.F.R. § 164.502(g)(3)(i).
[17] *Id.*
[18] 42 C.F.R. § 59.11.
[19] 42 C.F.R. §§ 2.11, 2.14.
[20] 45 C.F.R. §§ 164.502(g)(1); (g)(3); (a)(1)(i); (a)(2)(i); 164.524.
[21] 45 C.F.R. § 164.502(g)(3)(ii).
[22] 45 C.F.R. §§ 164.502(a)(1)(i)&(iv); (a)(2)(i); (g)(1); (g)(3)(i); (g)(5).

- ***Risk of Domestic Violence/Abuse/Neglect/Endangerment if Records Disclosed***

Health care providers who are covered under the HIPAA Privacy Rule may refuse to provide parents (known as personal representatives) access to a minor's medical records, even when parents otherwise would have a right of access, if:

(1) The providers have a "reasonable belief" that:
(A) The minor has been or may be subjected to domestic violence, abuse or neglect by the parent, guardian or other giving consent; or
(B) Treating such person as the personal representative could endanger the minor; and:

(2) The provider, in the exercise of professional judgment, decides that it is not in the best interest of the minor to give the parent, guardian or other such access.[23]

Providers should consult with their legal counsel before using their discretion to deny access to records under this law.

Laws That Explicitly Limit or Grant Access to Medical Information Based on Type of Medical Service:

- ***Abortion Services***

Minors have a right to obtain an abortion on their own accord. However, the minors' parents must be notified at least 48 hours before the procedure takes place in most but not all cases. State law prescribes the required reporting procedure, including who must provide notice, and how such notice should be delivered.

Exceptions to Notice Requirement:

There are exceptions to this notification requirement. For example, there are provisions for notice to just one parent as well as to alternate caretakers, such as a foster parent, court-appointed guardian, or an adult relative, when certain circumstances exist.

Further, notification is not required in the following circumstances:

(1) when the person or persons entitled to notice certify in writing that they have been notified;

(2) when "the pregnant minor declares that she is a victim of child abuse or neglect by the acts or omissions of the person who would be entitled to notice" and the physician has reported the abuse (in making the child abuse report, "the physician shall not reveal that he or she learned of the abuse or neglect as the result of the minor seeking an abortion.");

(3) when the attending physician certifies in the pregnant minor's medical record that there is a medical emergency as defined by the statute and there is insufficient time to provide notice; or

(4) when the minor petitions for and obtains a valid court order, pursuant to § 12-37.5-107. This is

[23] 45 C.F.R. § 164.502(g)(5).

known as "judicial bypass."

Judicial Bypass:
If a minor does not want her parents notified, the minor may elect to petition the court for permission to proceed without parent notification. When a minor petitions for a court order, the judge must grant the minor's petition if the judge finds that giving the notice is not in the best interest of the minor, or if the judge determines, "by clear and convincing evidence, that the minor is sufficiently mature to decide whether to have an abortion." C. R. S. § 12-37.5-107. For a full description of the notification requirement, its exceptions, and the judicial bypass process, *see* C.R.S. §§ 12-37.5-103 through 105.

- ***Alcohol and Drug Abuse Treatment/Emergency Treatment of Intoxication***

There are different confidentiality rules under federal and state law. Providers meeting the criteria in footnote 24 must follow the federal regulations as well as applicable state law to the extent possible.[24] Providers that don't meet the federal criteria must follow applicable state law.

Federal regulations:

For individuals or programs meeting the federal criteria, federal law generally prohibits disclosing any drug or alcohol treatment information to parents without the minor's written consent. This includes disclosure of patient identifying information to a parent for purpose of obtaining financial reimbursement. One exception is that an individual or program may share certain information with parents if the individual or program director determines the following three conditions are met:

1. The minor's situation poses a substantial threat to the life or physical well-being of the minor or another;

2. This threat may be reduced by communicating relevant facts to the minor's parents; and

3. 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.[25]

In such a case, the individual or program may share with parents any facts relevant to reducing the threat.

Colorado law:

For programs licensed to treat minors by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services, the general rule is that "[w]ritten information about minors'

[24] 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; 2.12).

[25] 42 C.F.R. § 2.14.

treatment, including dates/times of admission or discharge, shall not be disclosed to parents or legal guardians without minors' express written consent, in accordance with federal and state confidentiality regulations." However, there is an exception to this rule that allows notification to parents if all three of the following conditions are present:

1. In the judgment of the treatment director or designated staff, minors do not have the capacity to rationally decide whether to consent to notification due to age or medical and/or mental conditions;

2. Disclosure is necessary to protect the lives or well being of minors or others; and

3. Essential medical information is necessary for parents or legal guardians to make informed medical decisions on behalf of minors.[26]

Colorado law for emergency treatment of intoxication or incapacitation by alcohol:
When a person is admitted for emergency treatment for intoxication or incapacitation by alcohol to an approved treatment facility[27],"his or her family or next of kin shall be notified as promptly as possible." An exception to this requirement exists for adults who request that there be no notification.[28]

- ***Family Planning Services (Title X funded)***

The Title X Family Planning program is part of the federal Public Health Service Act and funds family planning programs nationally. For more information and a list of Title X funded providers in Colorado, see www.cdphe.state.co.us/pp/womens/famplan.html.

When providing Title X funded care, health care providers must follow federal Title X law and regulations.[29] Federal regulations implementing the Title X program require health care providers to keep personal information regarding Title X funded services confidential and require that providers obtain written authorization to release that information in most cases. The minor patient signs the authorization to release his or her Title X service information. Parents cannot access or obtain information about their minor child's Title X services without their child's written permission.[30] Title X regulations preempt state law if the state law would limit access or eligibility to the services provided through Title X.[31]

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[26] 6 Colo. Code Regs. § 1008-1 (15.225.3).

[27] Colo. Rev. Stat. § 27-81-102(2&3)("'Approved private treatment facility' means a private agency meeting the standards prescribed in section 27-81-106 (1) and approved under section 27-81-106….'Approved public treatment facility' means a treatment agency operating under the direction and control of or approved by the unit or providing treatment under this article through a contract with the unit under section 27-81-105 (7) and meeting the standards prescribed in section 27-81-106 (1) and approved under section 27-81-106.").

[28] Colo. Rev. Stat. § 27-81-110(5).

[29] *See* 42 U.S.C. § 300; 42 C.F.R. § 59.1.

[30] 42 C.F.R. § 59.11.

[31] *See Planned Parenthood Federation v. Heckler*, 712 F. 2d 650, 663-664 (D.C. Cir. 1983)("[U]nder the Supremacy Clause of the Constitution states are not permitted to establish eligibility standards for federal assistance programs that conflict with the existing federal statutory or regulatory scheme."); *Planned Parenthood Assoc. of Utah v. Matheson*, 582 F. Supp. 1001, 1006 (D. Utah 1983); *see also County of St. Charles v. Missouri Family Health Council*, 107 F.3d 682 (8th Cir. 1997); *Does 1-4 v. Utah Dept. of Health*, 776 F.2d 253 (10th Cir. 1985); *Doe v. Pickett*, 480 F. Supp. 1218, 1220-1221 (D.W.Va. 1979).

- ***Family Planning Services (funded by other than Title X)***

  Family planning records for services funded by other federal programs, such as Medicaid, are protected by separate federal confidentiality rules. The federal and state constitutions, as well as state policy on family planning, also provide a separate basis for providers to keep minors' family planning information confidential. Providers of family planning services should speak to legal counsel for further guidance on how and when the federal constitution and these other rules apply in this context.

- ***HIV Testing and Treatment***

  If the services are funded by Title X, then Title X confidentiality regulations apply. Federal regulations implementing the Title X program require health care providers to keep personal information regarding Title X funded services confidential and require that clinics obtain written authorization to release that information in most cases. The minor patient must sign an authorization to release his or her Title X service information. Parents cannot access or obtain information about their minor child's Title X services without their child's written permission.[32] If a state law conflicts with a Title X regulation, the Title X regulation preempts the state law if the state law would limit access or eligibility to the services provided through Title X.[33]

  When services are funded by other programs, state law likely applies. When a minor obtains HIV related medical services on his or her own accord, state law says "[t]he fact of consultation, examination, and treatment of such a minor … shall be absolutely confidential and shall not be divulged … except for purposes of [required public health or child abuse reporting]. If the minor is less than sixteen years of age or not emancipated, the minor's parents or legal guardian may be informed by the facility or physician of the consultation, examination, and treatment. The physician or other health care provider shall counsel the minor on the importance of bringing his parents or guardian into the minor's confidence about the consultation, examination, or treatment."[34]

- ***Mental Health Treatment***

  When a minor consents to his or her own mental health services, the "[p]rofessional person rendering mental health services to a minor may, with or without consent of the minor, advise the parent or legal guardian of the minor of the services given or needed."[35]

- ***Sexually Transmitted Infections, Testing and Treatment***

  If the services are funded by Title X, then Title X confidentiality regulations apply. Federal regulations implementing the Title X program require health care providers to keep personal information regarding Title X funded services confidential and require that clinics obtain written

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[32] 42 C.F.R. § 59.11.

[33] *See Planned Parenthood Federation v. Heckler*, 712 F. 2d 650, 663-664 (D.C. Cir. 1983)("[U]nder the Supremacy Clause of the Constitution states are not permitted to establish eligibility standards for federal assistance programs that conflict with the existing federal statutory or regulatory scheme."); *Planned Parenthood Assoc. of Utah v. Matheson*, 582 F. Supp. 1001, 1006 (D. Utah 1983); *see also County of St. Charles v. Missouri Family Health Council*, 107 F.3d 682 (8th Cir. 1997); *Does 1-4 v. Utah Dept. of Health*, 776 F.2d 253 (10th Cir. 1985); *Doe v. Pickett*, 480 F. Supp. 1218, 1220-1221 (D.W.Va. 1979).

[34] C.R.S. § 25-4-1405(6).

[35] C.R.S. § 27-65-103(2). *See also* C.R.S. § 27-65-121 regarding confidentiality of mental health treatment records and who may authorize their release.

authorization to release that information in most cases. Parents cannot access or obtain information about their minor child's Title X services without their child's written permission.[36]

In most other cases, state law likely applies. C.R.S. § 25-4-402(4) allows minors to obtain diagnosis and treatment for sexually transmitted infections on their own accord. When a minor obtains STD services on his or her own accord, state law says "[n]othing in [the state laws regarding inspection of medical records] shall be construed to require a person responsible for the diagnosis or treatment of sexually transmitted infections … to release patient records of such diagnosis or treatment to a parent, guardian, or person other than the minor or his or her designated representative."[37]

- ***Services for Victims of a "Sexual Offense"***

For this purpose, "Sexual offenses" are defined in reference to Part 4 of Article 3 of Title 18 of the Colorado Revised Statutes. They include the crimes of sexual assault, sexual assault on a child, and unlawful sexual contact, among others.[38]
"Prior to examining or treating a minor [under this section], a physician shall make a reasonable effort to notify the parent, parents, legal guardian, or any other person having custody or decision-making responsibility with respect to the medical care of such minor of the sexual offense."[39]
After attempting to make the notification, the physician may treat the consenting minor whether or not the physician was able to make the notification and whether or not the notified party has consented. However, "if the person having custody or decision-making responsibility with respect to the minor's medical care objects to treatment, then the physician shall proceed straight to a child abuse report.[40]

Sexual assault and most sexual offenses against a minor are considered child abuse under Colorado law, and mandated reporters must report them as such to child protection or law enforcement. (For more information on mandated reporting, see the tool entitled "*Colorado Mandated Child Abuse Reporting*" in this toolkit).

[36] 42 C.F.R. § 59.11.
[37] *See* C.R.S. §§ 25-1-801(1)(d), 25-1-802(2).
[38] C.R.S. § 13-22-106.
[39] C.R.S. § 13-22-106(2)(a).
[40] C.R.S. § 13-22-106(2)(b).

FREQUENTLY ASKED QUESTIONS ABOUT MINOR CONSENT AND CONFIDENTIALITY

Q: Does a teen become emancipated once he or she becomes a parent, or once she becomes pregnant?	**A:** No. Becoming pregnant or a parent does NOT emancipate a minor in Colorado. A pregnant or parenting teen remains a minor in the eyes of the law. In order to consent for his or her own health care, a pregnant or parenting teen must meet one of the minor consent exceptions described in the tool entitled "Colorado Minor Consent Laws" also in this toolkit. (For example, any teen, including a pregnant or parenting teen, may consent for his or her own health care if the teen is 15 or older, living separately from his or her parents or guardian, and managing his or her own financial affairs.) Notably, a teen parent can consent for his or her child's health care in the same way any parent can – even if (as a minor), the teen may not be able to consent to his or her own care.
Q: May a school employee ever release confidential information from a student's "education record" if there is a health or safety emergency? If so, to whom?	**A:** Yes, a school employee may share personally identifiable information from the education record with certain parties in a health or safety emergency as follows: "Education records" are subject to FERPA. Under FERPA, a school employee may disclose personal information contained in the education record of a minor student with "appropriate parties" during a health or safety emergency, "if knowledge of the information is necessary to protect the health or safety of the student or other individuals."[i] For this purpose, the U.S. Department of Education has interpreted 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 a case-by-case basis.[ii] In an emergency, information may be shared with "appropriate parties." "Appropriate parties" may include law enforcement, parents, public health officials or trained medical personnel, among others.[iii]
Q: May a health care provider ever release confidential information protected by HIPAA if there is a health or safety emergency? If so, to whom?	**A:** Yes, a health care provider may share information otherwise protected by HIPAA in an emergency under certain conditions. HIPAA allows health care providers to disclose otherwise protected health information when the provider in good faith believes the disclosure is necessary to prevent a serious and imminent threat to the health or safety of a person, consistent with ethical standards. The disclosure must be to a person or persons the therapist believes can prevent or lessen the threat.[iv]
Q: In the confidentiality tool, I see that there are some situations in which a health care provider has the discretion to decide whether or not to inform parents when their child seeks or has sought particular medical care.	**A:** There are some situations in which the law allows providers to use their best professional judgment to decide whether to maintain adolescent confidentiality or to share patient information with another, such as a parent. When the law gives providers discretion to share information or keep it confidential, providers sometimes wonder how to make this decision. Providers may want to consider a number of tools and resources in making this judgment, including the ethical principles of their profession, model standards of clinical practice, as well as current research. The Society for Adolescent Health and Medicine (SAHM) and the American Academy of Pediatrics both have issued position

How do I exercise this discretion?	papers that discuss these resources and apply them to the issue of confidentiality in adolescent health. The SAHM position paper is included in this toolkit for further reference. In general, discretion means that confidentiality can and usually should be maintained. When a provider does determine that information must be shared because, for example, the minor is at risk of harm or the disclosure is necessary to provide adequate treatment, the provider should explain to the minor the reasons why this needs to occur and, if possible, the provider should engage the minor in deciding how the information will be shared, and by and with whom.
Q: May a health care provider whose records are subject to FERPA promise students that their parents will not have access to "minor consent" information in their education record?	**A:** 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 minor child if they choose to do so.[v] 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. 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 or school health providers 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 part of the education record, (such as information in personal notes), the information would not be subject to FERPA. It should be noted that this answer does not take into account Colorado 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. State law also may impose affirmative reporting obligations on certain school employees. Providers should seek guidance from their own legal counsel regarding these issues.
Q: What if I have used my clinical judgment to determine that patient confidentiality should be protected, but I believe that I cannot guarantee confidentiality in my clinic due to clinic policies, funding, insurance or other issues?	**A:** If a provider believes that he or she cannot promise confidentiality to an adolescent patient when the provider feels it is necessary, the provider should refer the patient to a clinic that can better meet the confidentiality needs of the patient. For example, if a school nurse cannot guarantee confidentiality to a student seeking information about contraception, the nurse may consider referring the patient to a Title X clinic. Providers in Title X-funded clinics are bound by different federal confidentiality laws than nurses employed by most schools. See the tool entitled "Confidentiality of Adolescent Medical Information Under Colorado Law" also in this toolkit, for more information on Title X laws. For this reason, it is helpful for providers to know the confidentiality policies of the other providers and agencies in their area.

[i] 34 C.F.R. §§ 99.31(a)(10) and 99.36. *See also* 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 pg 10.
[ii] 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.
[iii] *See id.* at pg 7; *see also* U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. *Joint Guidance*, at 10.
[iv] 45 C.F.R. § 164.512(j).
[v] 34 C.F.R. § 99.10.

MANDATED CHILD ABUSE REPORTING IN COLORADO

THE BASICS OF REPORTING

Q: Who is a mandated reporter?

A: The following persons are mandated reporters under Colorado law:

(a) Physician or surgeon, including a physician in training; (b) Child health associate; (c) Medical examiner or coroner; (d) Dentist; (e) Osteopath; (f) Optometrist; (g) Chiropractor; (h) Podiatrist; (i) Registered nurse or licensed practical nurse; (j) Hospital personnel engaged in the admission, care, or treatment of patients; (k) Christian science practitioner; (l) Public or private school official or employee; (m) Social worker or worker in any facility or agency that is licensed or certified pursuant to part 1 of article 6 of title 26, C.R.S.; (n) Mental health professional; (o)Dental hygienist; (p) Psychologist; (q) Physical therapist; (r) Veterinarian; (s) Peace officer as described in section 16-2.5-101, C.R.S.; (t) Pharmacists; (u) Commercial film and photographic print processor as provided in subsection (2.5) of this section; (v) Firefighter as defined in section 18-3-201(1), C.R.S.; (w) Victim's advocate, as defined in section 13-90-107(1)(k)(II), C.R.S.; (x) Licensed professional counselors; (y) Licensed marriage and family therapists; (z)Unlicensed psychotherapists; (aa) Clergy members in certain circumstances. (Clergy is defined by state law); (bb) Registered dietitian who holds a certificate through the commission on dietetic registration and who is otherwise prohibited by 7 CFR 246.26 from making a report absent a state law requiring the release of this information; (cc) Worker in the state department of human services; (dd) Juvenile parole and probation officers; (ee) Child and family investigators, as described in section 14-10-116.5, C.R.S.; (ff) Officers and agents of the state bureau of animal protection, and animal control officers; (gg) The child protection ombudsman as created in article 3.3 of this title; and (hh) Starting January 1, 2012, educators providing services through a federal special supplemental nutrition program for women, infants, and children, as provided for in 42 U.S.C. sec. 1786. Colo. Rev. Stat. [hereinafter "C.R.S."] § 19-3-304.

There are special reporting rules for employees of the public health department in some cases. See C.R.S. §§ 19-3-304, 25-1-122, and 25-4-1404.

Q: When must a mandated reporter file a child abuse report?

A: A mandated reporter "who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions that would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department or local law enforcement agency."

C.R.S. § 19-3-304.

There are special reporting rules for employees of the public health department in some cases.

See C.R.S. §§ 19-3-304, 25-1-122, and 25-4-1404.

Q: What if the mandated reporter learns of the abuse after the victim reaches age 18?

A: The reporting requirements do not apply if (1) the reporter learns of the abuse or neglect after the victim is 18 or older **and** (2) does not have reasonable cause to know or suspect that:

- The perpetrator has abused or neglected another child currently under the age of 18 or is in circumstances in which abuse likely could result, or
- The perpetrator is in a position of trust with a child currently under the age of 18.

C.R.S. § 19-3-304 (1)(b).

Q: What about the right to patient confidentiality?

A: Child abuse reporting is an exception to patient confidentiality under most confidentiality laws, including FERPA, HIPAA and federal Title X family planning regulations. A mandated reporter may share otherwise confidential health information with the county department or law enforcement for the purpose of child abuse reporting if the information is relevant to a mandated child abuse report.

WHAT IS REPORTABLE?

Q: What is reportable abuse or neglect?

A: "Child abuse or neglect" means an act or omission in one of several categories that threatens the health or welfare of a child. These categories include: Non-accidental Physical Injury, Neglect, Emotional Abuse, Unlawful Sexual Behavior (e.g. Sexual Assault, Incest, Sexual Exploitation, Pimping or Employing a minor for prostitution), and Drug Related Abuse or Neglect (either the presence of a child at a home where a controlled substance is manufactured, or a positive test for a schedule I or II drug at a child's birth unless the mother had lawful prescription).

See C.R.S. § 19-1-103 for full description of the categories of reportable acts and their definitions.

Q: What is reportable physical abuse?

A: Mandated reporters must make a child abuse report when they have reasonable cause to know or suspect that a child has been the victim of a "non-accidental physical injury" that threatens the health or welfare of the child.

See C.R.S. § 19-1-103(1)(a)(I).

Injuries that must be reported include: (1) evidence of bruising, bleeding, burns, fracture of any bone, subdural

hematoma, soft tissue swelling, malnutrition, failure to thrive, or death, when (2) the condition is not sufficiently explained or circumstances indicate that the condition may not be accidental.

See C.R.S. § 19-1-103(1)(a)(I).

Q: What is reportable sexual abuse?

A: Mandated reporters must make a child abuse report when they have reasonable cause to know or suspect that a child has been "subjected to **unlawful sexual behavior as defined in section 16-22-102(9), C.R.S**." See C.R.S. § 19-1-103(1)(a)(II)(emphasis added).

Section 16-22-1-2(9) defines "**unlawful sexual behavior**" as completion of any of the following criminal offenses or the criminal attempt to commit any of the following offenses:

- Sexual Assault, in violation of C.R.S. 18-3-402
- Sexual assault in 1st degree, in violation of C.R.S. 18-3-402 as existed prior to 7-1-00
- Sexual assault in second degree, in violation of C.R.S. 18-3-403 as existed prior to 7-1-00
- Unlawful sexual contact, in violation of C.R.S. 18-3-404
- Sexual assault in 3rd degree, C.R.S. 18-3-404, as existed prior to 7-1-00
- Sexual assault on a child, in violation of C.R.S. 18-3-405
- Sexual assault on a child by one in a position of trust, in violation of C.R.S. 18-3-405.3
- Incest, in violation of C.R.S. 18-6-302
- Trafficking in children, in violation of C.R.S. 18-3-502
- Sexual exploitation of children, in violation of C.R.S. 18-6-404
- Pandering of a child, in violation of C.R.S. 18-7-403
- Pimping of child, in violation of C.R.S. 18-7-405
- Soliciting for child prostitution, in violation of C.R.S. 18-7-402
- Internet sexual exploitation child, in violation of C.R.S. 18-3-405.4
- Internet luring, in violation of C.R.S. 18-3-306(3)
- Engaging in sexual conduct in correctional institution, in violation of C.R.S. 18-7-701

There are other offenses in this list as well. See C.R.S. 16-22-1-2(9) for the complete list of crimes constituting "Unlawful Sexual Behavior." Each of these offenses is specifically defined under state law. This document provides definitions for just a few of the above offenses in the answers to the following questions. A child abuse report must be made if anyone subjects or criminally attempts to subject a minor to any of the above offenses.

Q: What is "Sexual Assault" for the purpose of child abuse reporting?

A: "Sexual Assault" of a minor is reportable child abuse. "Sexual Assault" is defined as " knowingly inflict[ing]

sexual intrusion or sexual penetration[1] on a victim" in the following circumstances:

"(a) The actor causes submission of the victim by means of sufficient consequence reasonably calculated to cause submission against the victim's will; or

(b) The actor knows that the victim is incapable of appraising the nature of the victim's conduct; or

(c) The actor knows that the victim submits erroneously, believing the actor to be the victim's spouse; or

(d) At the time of the commission of the act, the victim is less than fifteen years of age and the actor is at least four years older than the victim and is not the spouse of the victim; or

(e) At the time of the commission of the act, the victim is at least fifteen years of age but less than seventeen years of age and the actor is at least ten years older than the victim and is not the spouse of the victim; or

(f) The victim is in custody of law or detained in a hospital or other institution and the actor has supervisory or disciplinary authority over the victim and uses this position of authority to coerce the victim to submit, unless the act is incident to a lawful search; or

(g) The actor, while purporting to offer a medical service, engages in treatment or examination of a victim for other than a bona fide medical purpose or in a manner substantially inconsistent with reasonable medical practices; or

(h) The victim is physically helpless and the actor knows the victim is physically helpless and the victim has not consented."

C.R.S. § 18-3-403.

Q: What is "Unlawful Sexual Contact" for child abuse reporting purposes?

A: "Unlawful Sexual Contact" with a minor is reportable child abuse. "Unlawful Sexual Contact" is defined as "knowingly subject[ing] a victim to any sexual contact[2]" when:

(a) The actor knows that the victim does not consent; or

(b) The actor knows that the victim is incapable of appraising the nature of the victim's conduct; or

(c) The victim is physically helpless and the actor knows that the victim is physically helpless and the victim

[1] C.R.S. § 18-3-401(5), (6)("**'Sexual intrusion'** means any intrusion, however slight, by any object or any part of a person's body, except the mouth, tongue, or penis, into the genital or anal opening of another person's body if that sexual intrusion can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse…**'Sexual penetration'** means sexual intercourse, cunnilingus, fellatio, analingus, or anal intercourse. Emission need not be proved as an element of any sexual penetration. Any penetration, however slight, is sufficient to complete the crime.").

[2] C.R.S. § 18-3-401(4)("**'Sexual contact'** means the knowing touching of the victim's intimate parts by the actor, or of the actor's intimate parts by the victim, or the knowing touching of the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact is for the purposes of sexual arousal, gratification, or abuse.").

has not consented; or

(d) The actor has substantially impaired the victim's power to appraise or control the victim's conduct by employing, without the victim's consent, any drug, intoxicant, or other means for the purpose of causing submission; or

(f) The victim is in custody of law or detained in a hospital or other institution and the actor has supervisory or disciplinary authority over the victim and uses this position of authority, unless incident to a lawful search, to coerce the victim to submit; or

(g) The actor engages in treatment or examination of a victim for other than bona fide medical purposes or in a manner substantially inconsistent with reasonable medical practices."

It also includes "induc[ing] or coerc[ing] a child by any of the means set forth in 18-3-402 to expose intimate parts or to engage in any sexual contact, intrusion, or penetration with another person, for the purpose of the actor's own sexual gratification."

C.R.S. § 18-3-404.

Q: Should sexual activity with a teen ever be reported as abuse based on age alone?

A: Yes in a few cases. "Child abuse or neglect" includes any case in which a minor is subjected to "unlawful sexual behavior" as that term is defined in Colorado law. C.R.S. § 19-1-103(1)(a)(II). Sexual activity between disparate age partners is "unlawful sexual behavior" in some circumstances and therefore must be reported as child abuse.

For example, it is "Sexual Assault" and therefore reportable child abuse when a minor

(1) Engages in "sexual intrusion" or "sexual penetration" (*see footnote one for definitions*) and

(2) At the time of the commission of the act:

- One partner was less than fifteen years of age and the other partner was at least four years older and not the spouse of the victim; or
- One partner was at least fifteen years of age but less than seventeen years of age and the actor is at least ten years older than the victim and is not the spouse of the victim.

See the tool titled "*When a Health Care Provider Must Report Sexual Activity*" in this toolkit for more detailed information.

Q: Does a mandated reporter have to report the sexual exploitation of a minor or the use of minors in prostitution or pornography?

A: Yes in most cases. "Child abuse or neglect" includes any case in which a minor is subjected to "unlawful

sexual behavior" as that term is defined in Colorado law. C.R.S. § 19-1-103(1)(a)(II). "Unlawful sexual behavior" is defined by reference to multiple criminal code sections. Several of the reportable offenses criminalize the sexual exploitation and trafficking of minors and the use of minors in prostitution and pornography. Here are just two examples:

(1) Mandated reporters must make a child abuse report if they have reasonable cause to know or suspect that a person did any of the following:

(a) Solicited another for the purpose of prostitution of a child or by a child;

(b) Arranged or offered to arrange a meeting of persons for the purpose of prostitution of a child or by a child; or

(c) Directed another to a place knowing such direction is for the purpose of prostitution of a child or by a child.

See C.R.S. § 18-7-402.

(2) Reporters also must make a child abuse report if they have reasonable cause to know or suspect that someone is "knowingly liv[ing] on or [being] supported or maintained in whole or in part by money or other thing of value earned, received, procured, or realized by a child through prostitution."

C.R.S. § 18-7-405.

See the answer to the question "what is reportable as sexual abuse" above for a complete list of reportable acts related to sexual exploitation, prostitution and pornography.

Q: What is reportable neglect?

A: Mandated reporters must make a child abuse report when they have reasonable cause to know or suspect that a child has been the victim of "neglect" that threatens the health or welfare of the child. "Child neglect" is an act or omission that threatens the health or welfare of a child, including any case in which a child is in need of services because the child's parents, legal guardian, or custodian failed to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take. It is not neglectful to include a recognized method of religious healing in lieu of medical treatment.

C.R.S. § 19-1-103(1)(a)(III).

Q: What is reportable emotional abuse?

A: Mandated reporters must make a child abuse report when they have reasonable cause to know or suspect that a child has been the victim of "child abuse or neglect" that threatens the health or welfare of the child. "Child abuse or neglect" is an act or omission that threatens the health or welfare of a child, including emotional abuse. For this purpose, "emotional abuse" means "an identifiable and substantial impairment of the child's

intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development."

C.R.S. § 19-1-103(1)(a)(IV).

THE REPORTING

Q: How and how quickly must a mandated reporter make a report?

A: "Reports of known or suspected child abuse or neglect… shall be made immediately to the county department or the local law enforcement agency and shall be followed promptly by a written report prepared by those persons required to report. The county department shall submit a report of confirmed child abuse or neglect within sixty days of receipt of the report to the state department in a manner prescribed by the state department."

C.R.S. 19-3-307 (2010).

Q: What information should the report include?

A: Child abuse reports should contain, when possible:

(a) "The name, address, age, sex, and race of the child;
(b) The name and address of the person responsible for the suspected abuse or neglect;
(c) The nature and extent of the child's injuries, including any evidence of previous cases of known or suspected abuse or neglect of the child or the child's siblings;
(d) The names and addresses of the persons responsible for the suspected abuse or neglect, if known;
(e) The family composition;
(f) The source of the report and the name, address, and occupation of the person making the report;
(g) Any action taken by the reporting source;
(h) Any other information that the person making the report believes may be helpful in furthering the purposes of [protecting children from child abuse or neglect]."

C.R.S. § 19-3-307(2.5)

There are special reporting rules for employees of the public health department in some cases. See C.R.S. §§ 19-3-304, 25-1-122, and 25-4-1404.

Q: What happens to the report?

A: The county department of social services must immediately send copies of abuse reports to the district

attorney's office and the local law enforcement agency.

Within 60 days of the report to the county department of social services, the department must submit reports of confirmed child abuse or neglect to the state department. C.R.S. § 19-3-307.

Peace officers and prosecutors also may respond. They will determine whether it is appropriate to file any criminal charges against the suspected abuser.

Q: Are there penalties for failing to report or making a false report?

A: Failing to report can lead to criminal charges and liability. While mandated reporters have immunity when they report in good faith, mandated reporters who knowingly make a false report can be subject to criminal and civil liability.

See C.R.S. §§ 19-3-309 and 19-3-304.

When Health Care Providers Must Report Sexual Activity under Colorado's Mandatory Child Abuse Reporting Law

In Colorado, most health care practitioners are mandated reporters of child abuse. Mandated reporters must report to the appropriate authorities when they have reasonable cause to know or suspect child abuse. Under Colorado law, sexual acts are reportable as child abuse in the following three circumstances:

1. Any Non-Consensual Sexual Contact[1], Penetration[2], or Intrusion[2] is Reportable

Knowingly subjecting a minor to sexual contact without the minor's consent is reportable child abuse. Consent requires "cooperation in act or attitude pursuant to an exercise of free will and with knowledge of the nature of the act. A current or previous relationship shall not be sufficient to constitute consent . . . . Submission under the influence of fear shall not constitute consent." C.R.S. § 18-3-401. See the tool entitled "*Mandated Child Abuse Reporting in Colorado*" for more details.

2. Sexual Penetration or Intrusion[2] is Reportable Based on Age Difference Between Partner and Patient in a Few Situations

Mandated reporters also must report sexual penetration or intrusion (not simply contact) with a minor based on the age difference between the patient and his or her partner (other than a spouse), according to the following:

Age of Patient ↓	Age of Partner →															
	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27+
11	CJ	CJ	CJ	4+	M	M	M	M	M	M	M	M	M	M	M	M
12	CJ	CJ	CJ	CJ	4+	M	M	M	M	M	M	M	M	M	M	M
13	CJ	CJ	CJ	CJ	CJ	4+	M	M	M	M	M	M	M	M	M	M
14	CJ	CJ	CJ	CJ	CJ	CJ	4+	M	M	M	M	M	M	M	M	M
15	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	10+	M	M
16	4+	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	10+	M
17	M	4+	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
18	M	M	4+	CJ	CJ	CJ										
19	M	M	M	CJ	CJ	CJ										
20	M	M	M	CJ	CJ	CJ										
21	M	M	M	CJ	CJ	CJ										
22	M	M	M	CJ	CJ	CJ										
23	M	M	M	CJ	CJ	CJ										
24	M	M	M	CJ	CJ	CJ										
25	M	M	M	10+	CJ	CJ										
26	M	M	M	M	10+	CJ										
27+	M	M	M	M	M	CJ										

KEY:

M = Mandated. A report is mandated based solely on the age difference between patient and partner.

4+ = Mandated. A report is mandated if the older partner is 4 or more years older than the younger partner. For example:
-Minor is 14 and partner is 18 years old or older, or
-Minor is 13 and partner is 17 years old or older.

10+= Mandated. A report is mandated if the older partner is 10 or more years older than the younger partner. For example:
-Minor is 15 and partner is 25 years old or older, or
-Minor is 16 and partner is 26 years old or older.

No reports are required if minor and partner are both 17 or older.

CJ = Clinical Judgment. A report is not mandated based solely on age of participants; however, a reporter must use clinical judgment and must report if he or she has a reasonable suspicion that the act was non-consensual.

Chart design by David Knopf, LCSW, UCSF. See next page for legal sources for this chart.

3. OTHER REPORTING OBLIGATIONS:

This worksheet is not a complete review of all Colorado sexual abuse reporting requirements. It only addresses reporting of sexual contact and sexual penetration between certain parties. It does not address reporting requirements when sexual activity occurs between persons with a special relationship, such as family or persons in a position of trust, or reporting of other sexual activity such as sexual exploitation, prostitution or pornography. For more information on other reporting requirements and how to report, see the document entitled "*Mandated Child Abuse Reporting in Colorado*" in this toolkit.

Definitions:

[1]"**'Sexual contact'** means the knowing touching of the victim's intimate parts by the actor, or of the actor's intimate parts by the victim, or the knowing touching of the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact is for the purposes of sexual arousal, gratification, or abuse." C.R.S. § 18-3-401(4).

[2]"**'Sexual intrusion'** means any intrusion, however slight, by any object or any part of a person's body, except the mouth, tongue, or penis, into the genital or anal opening of another person's body if that sexual intrusion can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse…**'Sexual penetration'** means sexual intercourse, cunnilingus, fellatio, analingus, or anal intercourse. Emission need not be proved as an element of any sexual penetration. Any penetration, however slight, is sufficient to complete the crime." C.R.S. § 18-3-401(5), (6).

Legal Sources for this Chart:

Colo. Rev. Stat. §§ 19-3-304(mandated child abuse reporting); 19-1-10(defining child abuse as unlawful sexual behavior); 16-22-102(defining unlawful sexual behavior); 18-3-404(defining reportable unlawful sexual contact); 18-3-402(defining reportable sexual assault).

IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS?

OFFICE SELF-ASSESSMENT CHART

Take a moment to complete this self assessment to see how your office scores.			Yes	No
STAFF	Knowledge	Staff is educated regarding the minor consent and confidentiality laws that pertain to adolescents. Reference materials are available for all staff.		
	Policies	When a minor requires confidentiality and 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 explain confidentiality and limitations.		
	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.		
HANDOUTS AND MATERIALS	Discrete	Literature is small enough to fit into a wallet or purse.		
	Accessible	Education 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 if they are present.		
		Situations in which confidentiality may be breached are		

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		discussed.		
		A sign in the exam room encourages patients to ask questions.		
	Private	Patients are given privacy when changing clothes.		
		Doors are closing during history taking, counseling, and physical exams.		
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.		
	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 reminders are okay.		
		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 the mail at the clinic.		
BILLING	Procedures	Special considerations are made to safeguard confidential visit information for adolescents with private insurance. (Please refer to CASBHC's paper titled "Cost Recovery and Reduction Strategies for Providing Reproductive Health Services in SBHCs).		
		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 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 for suggestions on confidentiality conscious policies for the systems in your type of practice.

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CONFIDENTIALITY CONSCIOUS BACK-OFFICE POLICY RECOMMENDATIONS

The following administrative policies are necessary in any practice setting for the promotion and protection of adolescent confidentiality.

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 or sensitive information is imperative so that all personnel (including registration and lab) are able to maintain adolescents' confidentiality when appropriate.

- Front and Back Office Staff: All staff are trained to look for confidential and sensitive charts and treat them accordingly.

SENSITIVE BILLING PRACTICES

- For sensitive services, request 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 or sensitive services.

DIFFERENT TYPES OF PRACTICES WILL REQUIRE ADDITIONAL OR SPECIALIZED POLICIES

Special Considerations for Privately Insured Patients

While Medicaid and other types of public coverage generally avoid sending explanation of benefits (EOBs) 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. *Please note that the insurer is not obligated to comply with the request.*

POLICY RECOMMENDATIONS

- Ensure that patients seeking confidential or sensitive services are aware that they may ask their insurer not to send an EOB or to 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.

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- Training billing, claims or other appropriate staff to flag or contact privately insured patients receiving sensitive care to warn them that an EOB containing information may be sent to their home address. Patients receiving sensitive 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 it if sent unintentionally.

- When disclosing medical records of a minor to the parent of that minor, confidential 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.

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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 adolescent visit. The participation of a parent/caregiver in the adolescent's visit is invaluable and should be encouraged. That said, the adolescent may not disclose essential information 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.
  Introduce the concept of fostering adolescent self-responsibility and self-reliance.
  Reinforce that this policy applies to all adolescents in your practice or clinic (in other words, this is not specific to a particular adolescent).
  Acknowledge that although the adolescent is a minor, they do have specific legal rights related to consent and confidentiality.
  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 sensitive information may need to be shared.
- 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 the 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 his or her parent or other responsible adult as appropriate to the individual circumstances.
- Explore approaches the adolescent might use to facilitate this discussion (how does he or she 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 minor consent services and confidential care. The policy should be clearly outlined on the SBHC consent form. This will help prepare families for the adolescent visit.
- Explain the separation of the parent and the adolescent 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), 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.

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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 Colorado, for 13 year old patients, it is important to emphasize that if they tell you that they are having sex with a partner who is 4 or more years older, 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 Colorado, for 17 year old patients, the focus would shift to a discussion of their risk of being reported as a perpetrator of child sexual abuse if they tell you that a partner is 4 or more years younger.

COMMUNICATE CARING AND CONCERN

- Always frame information about your need to share sensitive information (for child abuse reporting, or 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 he or she told you in confidence.

KNOW THE LAW

- Be very familiar with Colorado 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 he or she understands about confidentiality to avoid any misperceptions.
- If you're unsure about a situation or question that comes up about confidentiality, say that you need to check out the facts and then get back to the client in a timely fashion.

DOCUMENT YOUR COMMUNICATIONS, UNDERSTANDING, AND ACTIONS IN THE MEDICAL RECORD

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FOR SCHOOL-BASED HEALTH CENTER PROVIDERS AND SCHOOL HEALTH PROVIDERS

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

The confidentiality rules described in other parts of this toolkit apply when health and mental health services are provided in a traditional clinical setting. When services are provided to minors on primary and secondary school grounds, 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).

Q: What is FERPA?	**A:** The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of personally identifiable student information held by "educational agencies or institutions" that receive federal funds under programs administered by the U.S. Secretary of Education.
Q: What information does FERPA protect?	**A:** FERPA controls disclosure of "education records" and the "personally identifiable information" contained in these records.[i] "Education records" are defined as records, files, documents, and materials recorded in any other format 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.[ii] "Personally identifiable information" 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."[iii] The health records of students under age 18 maintained by a school nurse are part of the "education record," as are immunization records housed in student education files.[iv] On the other hand, some information is not part of the education record. 'Personal records' are not subject to FERPA. 'Personal records' are notes kept in the maker's possession, used only as a memory aid, and not accessible to or shared with anyone except a temporary substitute.[v] The health records of students 18 and older are not always "education records" subject to FERPA.[vi] See footnote for more information.
Q: FERPA protects records maintained by an educational agency or institution, or a person acting for such an agency. **What is an "educational agency or institution?"**	**A:** "Educational agencies or institutions" are public or private institutions that receive federal education funding directly or indirectly, and either (1) provide direct instruction to students, such as schools, or (2) direct or control schools, such as school districts and state education departments.[vii] Most public schools and public school districts receive some form of federal education funding and therefore are considered "educational agencies or institutions" under FERPA. Organizations and individuals that contract with or consult for an educational agency also may be subject to and/or required to comply with FERPA if certain conditions are met.[viii] These conditions are discussed in greater detail in the tool entitled "*What do I follow?*" In this toolkit.
Q: What are the general	**A:** Generally, FERPA prohibits educational agencies from releasing any personally identifiable information in the education record unless the

confidentiality requirements of FERPA?	agencies have written permission for the release.[ix] In most cases, a parent[x] must sign that release. When students are eighteen years old or older, they sign their own release forms.[xi] The release form must contain certain information in order to be valid.[xii] FERPA also requires educational agencies to allow parents to access their minor children's education records.[xiii]
Q: Are there any exceptions in FERPA that allow schools to share information without a signed release?	**A:** FERPA allows educational agencies and schools to disclose information in the education record in some circumstances without need of a written release.[xiv] Such circumstances include (but are not limited to): (1) **Directory Information:** Educational agencies such as schools may share "**directory information**" about students with the public if the school and district have first followed certain procedures defined in FERPA. The 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." [xv] (2) **Sharing with school officials with legitimate educational interests:** Schools also may share information in the education record with "school officials" in the same school who have a "**legitimate educational interest**" in the information. 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.[xvi] Certain policies must be in place at the district level in order to implement both of these exceptions. (3) **Emergencies, research and other circumstances**: Additional exceptions also exist, including exceptions that allow sharing information in **emergency situations**, for **research**, in relation to certain **legal proceedings**, and for **school transfers**, among others.[xvii] There are parameters and definitions related to each of these exceptions.
Q: Does Colorado have state laws on this issue?	**A:** Colorado state law also protects the confidentiality of information held by public schools, persons acting for the public school, and school districts within the state. Like federal law, Colorado state law also includes exceptions that allow release of "information directly related to a student" in certain circumstances.[xviii] For the most part, the rules, exceptions and definitions in Colorado law parallel those found in FERPA.

[i] *See* 20 U.S.C. § 1232g(a) and (b).

[ii] 20 U.S.C. § 1232g (a)(4)(A)(defining "education record"); 34 C.F.R. § 99.3("Record means any information recorded in any way, including, but not limited to, handwriting, print, computer media, video or audio tape, film, microfilm, and microfiche.").

[iii] 34 C.F.R. § 99.3 (defining "personally identifiably information").

[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 [hereinafter "Joint Guidance"],* November 2008, at page 2.

[v] 20 U.S.C.§ 1232g(a)(4)(B)(i); 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.").

[vi] 20 U.S.C § 1232g(a)(4)(B)(iv); 34 C.F.R. § 99.3 ("'Education Records'…(b) The term does not include: …(4)Records on a student who is 18 years of age or older, or is attending an institution of postsecondary education, that are:(i) Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a paraprofessional capacity; (ii) Made, maintained, or used only in connection with treatment of the student; and (iii) Disclosed only to individuals providing the treatment. For the purpose of this definition, "treatment" does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution…").

[vii] 34 C.F.R. § 99.1(a).

[viii] *Joint Guidance*, at 4-5.

[ix] 20 U.S.C. § 1232g(b).

[x] For this purpose, parent includes "a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian." 34 C.F.R. § 99.3.

[xi] Students who are 18 or older are considered "eligible students." 34 C.F.R. § 99.3. "Eligible students" sign their own consent form. 34 C.F.R. § 99.5.

[xii] 20 U.S.C. § 1232g(b)(2)(A); 34 C.F.R. § 99.30(b)("The written consent must: (1) Specify the records that may be disclosed; (2) State the purpose of the disclosure; and (3) Identify the party or class of parties to whom the disclosure may be made.")

[xiii] 20 U.S.C. § 1232g(a)(1).

[xiv] 34 C.F.R. § 99.31.

[xv] 20 U.S.C. § 1232g(a)(5)(A).

[xvi] *See* 34 C.F.R. § 99.31(a)(1)(i) for more on "school official" and "legitimate educational interest."

[xvii] See 34 C.F.R. § 99.31 for more on these and the other circumstances.

[xviii] Colo. Rev. Stat. § 22-1-123; Colo. Rev. Stat. § 24-72-204(3).

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 these 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 HIPAA 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 Medicaid and CHP+), 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

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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 representative 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 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.

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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 Colorado 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 Health and Human Services (HHS). OCR has established a website 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 the 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

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DOES HIPAA OR FERPA APPLY TO HEALTH RECORDS AT A SCHOOL SITE?

Q: Is it possible for health records to be subject to FERPA?	**A:** Yes. Health information will be subject to FERPA confidentiality and release rules if the health information is held in an "education record."[i]
Q: Is it possible for a health record to be subject to FERPA and HIPAA at the same time?	**A:** No. The HIPAA Privacy Rule explicitly states that its rules *do not apply* to health information held in an education record subject to FERPA.[ii] Therefore, if FERPA applies, the HIPAA Privacy Rule does not.
Q: I am a primary or secondary school nurse or school mental health clinician employed by a local public school district. **Are my client health records subject to HIPAA or FERPA?**	**A:** Student health records maintained by a public school nurse or licensed psychologist or counselor employed by the school or district typically are subject to FERPA. In general, a school nurse's or clinician's records are considered "education records" subject to FERPA, as they contain information related to a student and were created and are being maintained by a school employee or agent.[iii] There are a few situations in which student health information maintained by a school employee would not be part of the "education record" subject to FERPA. Here are just two examples: (1) If any student's personal health information is in a school nurse's or clinician's 'personal record,' it is not subject to FERPA. (See footnote for definition of 'personal record.').[iv] (2) If the student health record is about a student eighteen years old or older, and the record meets the definition of "treatment record," (see footnote) [v], then the record is not subject to FERPA. If not subject to FERPA, the records may be subject to the HIPAA Privacy Rule, but only if the school nurse or clinician is a "covered entity" as defined in HIPAA.[vi]
Q: I am a health care provider from a private agency who sometimes provides services at a school campus. **Are my client health records subject to HIPAA or FERPA?**	**A:** It depends. Whether the records of a school health program or provider are subject to HIPAA or FERPA will depend in part on whether the program or provider can be considered an "educational agency" or the agent of one, and this will depend on a number of factors. While there is no clear-cut checklist to apply, "Joint Guidance" issued by the U.S. Department of Education (DOE) and the U.S. Department of Health and Human Services (DHHS) provides some case examples that suggest factors these agencies would use to determine which law applies. In addition, several compliance letters issued by U.S. DOE provide case examples that shed light on how DOE interprets FERPA application. Some of these examples are described on the next page.

Examples from U.S. DOE and DHHS	
HIPAA applies:	• The University of New Mexico asked the U.S. Department of Education for some guidance regarding the intersection of FERPA and state law in relation to the University's student health center medical records. In its response, the DOE addressed, as a preliminary matter, whether a student health center's records are "education records" subject to FERPA. The DOE said that the health records of a campus based health center 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*."[vii] • In Joint Guidance issued by the U.S. Departments of Education (DOE) and Health and Human Services (DHHS), DOE and DHHS posed the question: "*Does FERPA or HIPAA apply to records maintained by a health care provider not employed by a school?"* Their response was as follows: • "*Some outside parties provide services directly to students and are not employed by, under contract to, or otherwise acting on behalf of the school. In these circumstances, these 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. For example, the records created by a public health nurse who provides immunization or other health services to students on school grounds or otherwise in connection with school activities but who is not acting on behalf of the school would not be "education records" under FERPA."*[viii]
FERPA applies:	• In the "*Joint Guidance*," DOE and DHHS said the following in response to the question: "*Does FERPA or HIPAA apply to records maintained by a health care provider not employed by a school?"* • *"If a person or entity acting on behalf of a school subject to FERPA, such as a school nurse that provides services to students under contract with or otherwise under the direct control of the school, maintains student health records, these records are education records under FERPA, just as they would be if the school maintained the records directly. This is the case regardless of whether the health care is provided to students on school grounds or off-site*."[ix] • DOE and DHHS also suggest that a health provider or program's records 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 entirely by an outside agency. The "*Joint Guidance*" provides 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."[x]
Q: My situation doesn't sound exactly like any of those described above. How do I know if my records are subject to HIPAA or FERPA?	**A:** 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.

[i] See 20 U.S.C. § 1232g(a), (b).

[ii] 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; ….").

[iii] 20 U.S.C. § 1232g(a)(4)(A); 34 C.F.R. § 99.3.

[iv] 20 U.S.C. § 1232g(a)(4)(B)(i); 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.").

[v] 20 U.S.C. § 1232g(a)(4)(B)(iv); 34 C.F.R. § 99.3("'Education Records'…(b) The term does not include: …(4)Records on a student who is 18 years of age or older, or is attending an institution of postsecondary education, that are:(i) Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a paraprofessional capacity; (ii) Made, maintained, or used only in connection with treatment of the student; and (iii) Disclosed only to individuals providing the treatment. For the purpose of this definition, "treatment" does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution…").

[vi] Only health care providers that are "covered entities" must comply with the HIPAA Privacy Rule. 45 C.F.R. § 164.500(a). Covered entities include health care providers that conduct certain transactions in electronic form, such as electronic insurance billing. See 45 C.F.R. § 160.103(defining "covered entity").

[vii] 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

[viii] 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 4-5.

[ix] *Joint Guidance* at page 4.

[x] *Joint Guidance* at page 4.

WHY DOES IT MATTER WHETHER MY RECORDS ARE SUBJECT TO HIPAA OR FERPA?

The Privacy Rule under the federal Health Insurance Portability and Accountability Act (HIPAA) protects and controls disclosure of personal health information held by health care providers who are "covered entities." The federal Family Educational Rights and Privacy Act (FERPA) protects and controls disclosure of personal health information held in an "education record." In many ways, the two federal laws are similar. Where they differ is in the details, and these differences matter. Whether a health record is protected by FERPA or HIPAA will impact service provision, administrative policies and paperwork, and the provider's relationships with other agencies among other things. Here are just a few examples of their similarities and differences:

Authorization to Release Information	
Similarities between HIPAA and FERPA	**Differences between HIPAA and FERPA**
Both HIPAA and FERPA typically require a written release before protected information can be disclosed. Both require that the release form contain certain elements and information to be valid.	The person(s) authorized to sign a release of information is different under HIPAA and FERPA. Both HIPAA and FERPA have their own unique list of elements, notices and information that a release form must contain to be valid.
Parent / Child Access and Control	
Similarities between HIPAA and FERPA	**Differences between HIPAA and FERPA**
Both allow parents to access records about their child in some situations.	A parents' right to access their child's health file is much broader under FERPA than HIPAA. A minor has more power to control and limit release of his or her own health record under HIPAA than FERPA.
Disclosures without Need of Written Release	
Similarities between HIPAA and FERPA	**Differences between HIPAA and FERPA**
Both contain exceptions that allow sharing information without a written release in some cases. A few of these exceptions are similar – for example, both HIPAA and FERPA contain exceptions that allow sharing protected information for research purposes, in emergencies and for child abuse reporting without need of a release.	There are exceptions under each law that do not exist under the other. For example, FERPA allows school employees to disclose records subject to FERPA to teachers and other "school officials" without need of a release, as long as that school official has a "legitimate educational interest" in the information. No similar exception exists in HIPAA; A health provider whose records are subject to HIPAA cannot disclose information to a teacher without a signed authorization to release. By contrast, HIPAA allows health providers to disclose individual health information for treatment purposes to a provider working with the same client in another agency or clinic. FERPA does not contain a similar exception. Even where similar exceptions exist, they can apply in different ways. For example, under both FERPA and HIPAA, providers may disclose protected information when a youth in in danger, but how danger is defined under each law and to whom the provider may disclose that information is different under HIPAA and FERPA.
Please refer to other tools in this toolkit for more detail about HIPAA and FERPA.	

HANDOUTS FOR YOUTH AND PARENTS

DISCLAIMER: 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.

TEEN HEALTH RIGHTS AND RESPONSIBILITIES

AN AGREEMENT BETWEEN YOU AND YOUR HEALTH CARE PROVIDER

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 health care provider know if my heath changes.
- Follow the plan that I choose with my doctor or nurse, and tell him or 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!**

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DERECHOS Y RESPONSABILIDADES ACERCA DE LA SALUD DE LOS JÓVENES ADOLESCENTES

UN ACUERDO ENTRE TÚ Y TU MÉDICO

Como joven,

Tengo el DERECHO a:

- Ser respetado/a.
- Recibir información médica correcta y completa.
- Hacer preguntas.
- Entender los beneficios de mi seguro médico y el proceso de facturación.
- Revisar mis archivos médicos.
- Estar acompañado/a a la consulta médica por un pariente, un amigo o mi pareja.
- Visitar al médico sin estar acompañado/a en la sala de consulta médica por mis padres/tutor legal

Tengo la RESPONSABILIDAD de:

- Dar información honesta y decirle a mi doctor si experimento algún cambio de salud.
- Seguir el plan médico que el doctor o enfermera y yo elegimos, y comunicarle si decido cambiar el plan.
- Tratar con respeto a los empleados y otros pacientes de la oficina médica.
- Llegar a tiempo para las citas y llamar si necesito cancelar o cambiar una cita.

Cuando tenga alguna pregunta, **¡LA HARÉ!**

Cuando tenga alguna preocupación, **¡LA COMUNICARÉ!**

Cuando me guste lo que está pasando, **¡SONREIRÉ Y DARÉ LAS GRACIAS!**

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QUIZ: HOW WELL DO YOU KNOW YOUR HEALTH RIGHTS AND RESPONSIBILITIES?

TRUE OR FALSE?

A teen can see a doctor about birth control without his or her parent/guardian's consent.

TRUE: Colorado has laws that let a person of any age make their own choices about birth control, pre-natal care, adoption, and parenting.

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

TRUE: Colorado laws let people 15 or older get care for mental health issues without parental consent. Teens of any age can consent to care for sexually transmitted infections or drug and alcohol issues without parental consent.

A teen can always see a doctor without a parent's permission.

FALSE: Teens cannot see a doctor without their parents' permission for health services like treatment of injuries, colds, flu and physicals. The doctor will need a 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.

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¿QUÉ TAN BIEN CONOCES TUS DERECHOS SOBRE LA SALUD?

VERDADERO O FALSO:

Un joven adolescente puede ver a un doctor acerca de métodos anticonceptivos y el embarazo sin el consentimiento de sus padres/tutor legal.

VERDADERO: Las leyes de Colorado permiten que las personas de cualquier edad hagan sus propias decisiones con respecto a los métodos anticonceptivos, el embarazo, adopción y la crianza de niños.

Los jóvenes que tienen o son mayores de 15 años de edad pueden ver a un doctor acerca de la salud mental sin el consentimiento de sus padres. Los jóvenes de cualquier edad pueden ver a un doctor acerca del abuso del alcohol y las drogas, o enfermedades transmitidas sexualmente sin el consentimiento de sus padres.

VERDADERO: Las leyes de Colorado permiten que las personas que tienen o son mayores de 15 años de edad reciban cuidado médico para la salud mental. Los jóvenes de cualquier edad pueden ver a un doctor acerca de asuntos relacionados a las drogas y el alcohol, o enfermedades transmitidas sexualmente sin el consentimiento de sus padres.

Todos los asuntos médicos por los cuales un joven pudiera querer ver a un doctor son confidenciales.

FALSO: Ciertos servicios médicos, como el tratamiento de heridas, resfriados, gripe y exámenes físicos, NO son servicios confidenciales. El doctor necesitará el consentimiento de tus padres/tutor legal para estos servicios.

Un adolescente puede preguntarle al doctor qué información se mantendrá privada y qué información se compartirá con sus padres/tutor legal.

VERDADERO: Existen muchas leyes sobre qué información se puede compartir con tus padres/tutor legal. Es importante hablar con tu doctor para saber cuál información se mantendrá privado. En algunas situaciones, tú puedes decidir qué información se compartirá con tus padres/tutor legal.

A veces es bueno hablar con un adulto en que puedes confiar sobre tu salud o cambios en tu vida que te preocupan.

VERDADERO: Puedes hablar sobre tu salud o conseguir ayuda de un adulto en quien confíes, como tu padre, madre, tutor legal, maestro, amigo de la familia, terapeuta, o entrenador. Si tienes alguna pregunta acerca de un tema médico, un adulto de confianza puede darte consejos y opiniones importantes.

¡Responsabilizarte de tu salud es una parte importante de hacerse adulto!

VERDADERO: Para los adolescentes, responsabilizarse más y querer más privacidad son partes normales de madurar.

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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 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 www.talkingwithkids.org • Advocates for Youth www.advocatesforyouth.org • SIECUS—Families are Talking www.familiesaretalking.org • US Department of Health & Human Services—Parents Speak Up www.4parents.gov • Nickelodeon—Parents Connect www.parentsconnect.com

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¡TU HIJO/A ADOLESCENTE ESTÁ CAMBIANDO!

La adolescencia es un tiempo de crecimiento y cambio en la que su hijo/a adolescente se está convirtiendo en adulto.

Mientras su hijo/a adolescente va cambiando, el papel de usted como padre/madre también cambia. Con tu hijo/a adolescente de 12 años te relacionarás de manera diferente a como te relacionarás con tu hijo/a adolescente de 18 años. Es importante saber qué esperar, para poder darle a su hijo/a adolescente más responsabilidad y los mejores consejos posibles.

PUEDE SER QUE SU HIJO/A:

- Se independice más
- Quiera más responsabilidad
- Empuje barreras y pruebe límites
- Quiera que cambie la relación que tiene con usted
- Necesite más privacidad
- Sea temperamental
- Piense mucho más en sus propias preocupaciones personales
- Le dé más importancia a sus amigos
- Sienta que nadie le comprende
- Pruebe nuevos comportamientos y actividades tanto sanas como peligrosas
- Comprenda conceptos complicados en vez de sólo las relacionadas al presente

SU HIJO/A AÚN NECESITA QUE USTED:

- Le dedique tiempo
- Le haga sentirse conectado y que pertenece
- Le apoye
- Provea sus necesidades básicas
- Le guíe
- Le exprese su amor
- Ponga límites
- Preste atención a sus éxitos y comportamientos
- Participe y sea consciente de lo que está ocurriendo en su vida

RECUERDE:

¡Todos estos cambios son completamente normales! Su hijo/a aún le necesita a usted, pero puede que él o ella no siempre sepa cómo comunicar esa necesidad. Usted aún es la mejor persona para guiarlo/a, y es importante seguir comunicándose con él o ella.

Hable con el doctor o la enfermera de su hijo/a acerca de estos cambios y cualquier desafío que tenga con su hijo/a.

PÁGINAS WEB PARA PADRES Y MADRES:

RECURSOS	
	• Children Now and Kaiser Family Foundation www.talkingwithkids.org • Advocates for Youth www.advocatesforyouth.org • SIECUS—Families are Talking www.familiesaretalking.org • US Department of Health & Human Services—Parents Speak Up www.4parents.gov • Nickelodeon—Parents Connect www.parentsconnect.com

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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 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!**

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HABLE CON SU HIJO/A ADOLESCENTE SOBRE ASUNTOS DIFÍCILES

Los cambios naturales que ocurren durante los años de la adolescencia pueden resultar difíciles para usted y para su hijo/a. En muchas familias, puede haber desacuerdos cuando los hijos quieren más privacidad e independencia. Los padres pueden sentir que sus hijos/as son impulsivos e irrespetuosos.

Los adolescentes toman decisiones sobre cosas como el sexo, fumar, alcohol y drogas. Como adulto, usted también sigue tomando decisiones sobre estas cosas. Como padre/madre de un adolescente, usted tiene la oportunidad y responsabilidad de ayudarle a aprender a tomar decisiones sanas. Los adolescentes quieren información de y una relación estrecha con sus padres. Aunque pueda resultar difícil, es importante hablar con su hijo/a adolescente de manera abierta y a menudo sobre estos temas.

Consejos para hablar con su hijo/a adolescente:

Hable:	No tenga miedo de hablar sobre temas difíciles como el sexo y las drogas. Incluso si su hijo sólo tiene 10 u 11 años, usted puede hablar sobre la pubertad, presión social, y cómo mantenerse sanos. Esto le hará sentir mas cómodo/a hablar con usted de estos temas.
Escuche:	Es importante escuchar y estar abierto a las opiniones de su hijo/a adolescente. Trate de no interrumpir cuando le está diciendo su punto de vista.
Sea honesto:	Dé respuestas honestas cuando su hijo/a adolescente le pida información. No se preocupe si no tiene todas las respuestas.
Comparta sus ideas y opiniones:	Los adolescentes quieren oír acerca de sus valores y creencias.
Respete sus opiniones:	Los adolescentes maduran y se independizan. Permitirles tomar sus propias decisiones es una parte importante de crecer. Pídale a su hijo/a que comparta con usted sus ideas y opiniones. Asegúrese de dejarle saber que usted siempre está ahí para ayudar, incluso si usted no está de acuerdo con todas sus decisiones o su comportamiento.
Mantenga la calma:	Trate de permanecer tranquilo/a si le comunica un problema preocupante, para que no tenga miedo de hablar con usted.
Continúe hablando:	Inicie conversaciones acerca de los temas una y otra vez. No tema iniciar conversaciones sobre temas importantes de los que ya ha hablado. Use películas, programas televisivos o noticias sobre la salud de los adolescentes como manera de comenzar conversaciones.
	**¡NO TENGA MIEDO DE PEDIR AYUDA!**

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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 "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 Colorado law teens can get care without parent consent for some "sensitive" visits, such as those for:

- Birth control
- Sexually transmitted infections
- Sexual assault services
- Mental health counseling (for ages 15 and older)
- Alcohol and drug counseling

Don't I have a right to be involved in my teen's medical care? 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.

What will happen if my child is in danger?

If a doctor or nurse learns that a teen under 18 years is being abused, or is thinking about hurting him/herself or others, the proper authorities must be contacted for help.

Will my teen keep secrets from me since they can get services on their own?

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 of 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.

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AYUDE A QUE SU ADOLESCENTE SE RESPONSABILICE DE SU SALUD

Educar a hijos adolescentes puede resultar difícil. A veces quieren que uno esté con ellos y otras veces no. A veces son responsables y otras veces no. Los adolescentes necesitan padres involucrados en sus vidas, pero también necesitan privacidad con respecto a su salud. Cuando tienen privacidad, pueden hablar de manera abierta con su doctor sobre sus preocupaciones. Sin privacidad, es posible que eviten acceder servicios médicos. Estos servicios se llaman servicios "confidenciales" o "delicados."

Para casi cualquier tipo de cuidado médico, los padres necesitan dar su consentimiento y pueden saber si sus hijos visitan al doctor. Sin embargo, bajo la ley de Colorado los adolescentes pueden recibir cuidado médico sin consentimiento de los padres para visitas "confidenciales" o "delicadas." Estas incluyen vistas para:

- Métodos anticonceptivos
- Embarazo
- Enfermedades transmitidas sexualmente
- Servicios para víctimas de abuso sexual
- Terapia de salud mental (para 15 años y mayores)
- Terapia de alcohol y drogas

¿No tengo el derecho de saber qué cuidado médico está recibiendo mi adolescente? ¿Por qué puede ir al doctor mi hijo/a adolescente para estos asuntos serios sin mi permiso?

Cada estado tiene leyes que permiten que los niños menores de 18 años reciban ciertos tipos de cuidado médico sin el consentimiento de sus padres. Afortunadamente, LA MAYORÍA de los adolescentes SÍ les hablan a sus padres, y quieren que sus padres los aconsejen. ¡Usted tiene un papel muy importante en ayudarlos a estar sanos! Pero incluso si la relación entre usted y su hijo/a es fuerte, puede ser que él o ella desee ser responsable de algunas partes de su cuidado médico. Los adolescentes pueden sentirse avergonzados, apenados o asustados de hablar con sus padres de algunos temas. Puede ser que no vayan al doctor si piensan que la información no se mantendrá privada.

¿Qué pasará si mi hijo está en peligro?

Existen límites con respecto a la confidencialidad. Si un doctor o una enfermera descubre que un adolescente menor de 18 años está siendo maltratado, o está pensando en hacerse daño a sí mismo o a otra persona, esta obligado/a ponerse en contacto con las autoridades apropiadas para recibir ayuda.

¿Mi adolescente me ocultará información porque puede recibir servicios confidenciales?

Querer privacidad es una parte sana y normal de ser adolescente. Aunque algunos adolescentes pueden recibir algún cuidado médico sin permiso de los padres, los doctores y enfermeras los animan a que hablen con sus padres u otro adulto de confianza.

¿Cómo puedo dejarle saber a mi adolescente que quiero hablarle de estos temas?

Como padre/madre de un hijo/a adolescente, parte de su trabajo es ayudarle a aprender cómo tomar decisiones sanas. Están haciéndose más independientes, y tomar sus propias decisiones es una parte importante de su crecimiento. Asegúrese de dejarles saber que usted siempre está ahí para ayudar, incluso si usted no está de acuerdo con todas sus decisiones. Escuche, y cuando sea posible, mantenga la calma si le comunican un problema que es preocupante, para que continúen hablándole.

Adapted with permission from the California Adolescent Health Collaborative and the Adolescent Health Working Group.

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 the California Adolescent Health Collaborative and the Adolescent Health Working Group.

CONOCERME A MÍ MISMO/A ES CONOCER A MI HIJO/A ADOLESCENTE

A veces sus opiniones pueden impedir que usted escuche a su hijo/a adolescente con la mente abierta. Si los adolescentes se sienten juzgados por sus padres/madres o las personas que los cuidan, es menos probable que compartirán información delicada o vergonzosa. Hágase estas preguntas antes de hablar sobre temas delicados con su adolescente.

¿Cómo me siento?

¿Está usted de buen humor? ¿Qué memorias afectan sus opiniones? Recuerde que lo que usted vivió de adolescente tal vez no sea lo mismo que lo que está viviendo su hijo/a adolescente ahora.

¿Qué hacía yo a los 16 años?

¿Ha pensado usted en lo que quiere compartir con su adolescente? Espere hasta que su adolescente esté a la mitad de sus años de adolescencia antes de compartir información delicada con él o ella.

¿Estamos encontrando algún tiempo juntos para disfrutar el uno de la compañía del otro?

Puede resultar difícil de creer, pero la mayoría de los adolescentes dicen que desearían pasar más tiempo con sus padres y madres. Puede resultar más fácil hablar de temas difíciles si pasan tiempo haciendo cosas divertidas juntas, así como yendo de paseo, viendo películas, haciendo proyectos o compartiendo la hora de la comida.

¿Estoy escuchando a mi adolescente?

Pase tanto tiempo escuchando como hablando. Evite juzgar rápidamente. Si no comprende lo que le trata de decir su adolescente, repita delante de él o ella lo que dijo.

¿Juzgo demasiado rápidamente?

Pregúntele siempre a su adolescente lo que está haciendo en vez de pensar lo peor. Confíe en que él/ella puede tomar buenas decisiones.

¿Cuáles son mis reglas con respecto a la seguridad?

Dígale a su adolescente qué reglas ha de seguir por cuestiones de seguridad. Cumpla con las consecuencias si su adolescente se comporta de manera no segura. Hable de la importancia de la seguridad con regularidad, no solo una vez. Pida ayuda de inmediato si su adolescente se encuentra en una situación que no es segura.

¿Estoy dispuesto/a a recibir ayuda para cualquier problema que pudiera tener?

Es importante ser un ejemplo para su adolescente. Ver como recibe ayuda un miembro de la familia puede animar a su adolescente a recibir ayuda para sus propios problemas.

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THE 5 BASICS OF PARENTING ADOLESCENTS

1. LOVE AND CONNECT

Support and accept your teen as he or she 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 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 the 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 or her doctor every year, and any counseling that he or she needs.
- Reach out for support from other parents when you need it!

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LOS 5 PUNTOS PRINCIPALES PARA CRIAR A ADOLESCENTES

1. AMA Y CONECTA

Apoye y acepte a su adolescente a medida que se hace mayor. El mundo está cambiando. Asegúrese de que su amor hacia él o ella no cambie.

Consejos para padres y madres:

- Diga cosas buenas de su adolescente cuando haga algo bien.
- Apoye los intereses, las destrezas y los talentos de su adolescente.
- Pase tiempo a solas con él o ella, y en familia.
- Llegue a conocer a los amigos de su adolescente y a los padres, madres o personas que cuidan de él o ella.

2. MIRE Y OBSERVE

Hable con su adolescente para descubrir qué está pasando. Fíjese en las actividades de su adolescente. El que usted se interese es importante para él o ella.

Consejos para padres y madres:

- Hable con otros adultos en la vida de su adolescente.
- Sepa cuáles son las clases, calificaciones, trabajo e intereses de su adolescente.
- Sepa dónde está su adolescente, qué está haciendo, y con quién está.

3. ENSEÑE Y PONGA LÍMITES

Los límites protegen a su adolescente de situaciones no seguras y le dan espacio para madurar. Sea firme, pero también esté dispuesto o dispuesta a adaptar y cambiar de idea.

Consejos para padres y madres:

- Ayude al adolescente a tomar mejores decisiones enseñándole en lugar de empujándole.
- Sea firme con respecto a asuntos importantes así como la seguridad, e ignore los asuntos más pequeños.
- Sea consistente e implemente las consecuencias que establezca con su adolescente.
- Sea firme con respecto a las reglas sin llegar a los castigos físicos.
- Déle a su adolescente más responsabilidades y más libertad para tomar sus propias decisiones a medida que se vaya convirtiendo en adulto.

4. MUESTRE Y HABLE

Hable con su adolescente, apóyelo o apóyela, ¡y enseñe por medio del ejemplo!

Consejos para padres y madres:

- Dé un buen ejemplo comportándose como usted quiere que se comporte su adolescente.
- Halague los comportamientos y hábitos positivos de su adolescente.
- Déle a los adolescentes la oportunidad de resolver sus propios problemas y escoger por sí mismos.

5. PROVEA Y PROMUEVA

Los adolescentes necesitan que los padres y las madres les den comida, ropa, cobijo y cuidado médico. También necesitan un hogar amoroso, y adultos que muestran cariño en sus vidas.

Consejos para padres y madres:

- Busque buenas oportunidades y actividades para su adolescente.
- Asegúrese de que su adolescente asista a las visitas con su doctor cada año, y a cualquier terapia que necesite.
- ¡Pida apoyo de otros padres cuando lo necesite!

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

Why didn't my son come to me?

Don't my children trust me?

Am I not doing enough as a parent?

Why wouldn't my daughter want me to know what is going on with her health?

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 their 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 his or her health! But even when teens and parents have strong relationships, there are some issues that teens 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 their 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.

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¡MI HIJO/A ADOLESCENTE ESTA VISITANDO AL DOCTOR SIN AVISARME!

¿Por qué mi hijo/a no me dice a mi?

¿Mis hijos no confían en mí?

¿No estoy haciendo lo suficiente como padre/madre?

¿Por qué que mi hijo/a no quiere que yo sepa de su salud?

Usted se acaba de enterar de que su hijo/a adolescente está recibiendo servicios médicos sin avisarle. Como padre/madre, usted puede sentirse preocupado/a o afligido/a. Esto es normal. Pero trate de verlo así—su adolescente está siendo responsable por su propia salud. ¡Usted se puede sentir orgulloso/a!

RECUERDE:

- Su adolescente se está haciendo más independiente. Durante la adolescencia los jóvenes intentan llevarse más como adultos, y puede ser que deseen buscar ayuda solos. Esta es una parte importante de madurar.

- ¡Usted tiene un papel importante en la salud de su hijo/a! Pero incluso cuando los jóvenes y sus padres tienen una relación estrecha, hay algunos temas que ellos pueden desear hablar solo con el doctor.

- Nunca es tarde para hablar con su hijo/a adolescente sobre temas difíciles. Empiece hablando de sus propios valores y expectativas. Es importante que:
  - Se mantenga tranquilo/a
  - Escuche
  - Respete a las ideas de su hijo/a
  - Comparta sus pensamientos y opiniones
  - Tenga un diálogo con su hijo/a

- Los doctores y enfermeras quieren ayudarle y apoyarle a usted. Pídale ayuda si tiene preocupaciones o preguntas sobre su hijo/a adolescente.

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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 may 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 Colorado, teens can receive some types of health services on their own. We may not be able to 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 www.talkingwithkids.org • Advocates for Youth www.advocatesforyouth.org • SIECUS—Families are Talking www.familiesaretalking.org • US Department of Health & Human Services—Parents Speak Up www.4parents.gov • Nickelodeon—Parents Connect www.parentsconnect.com

Adapted with permission from the California Adolescent Health Collaborative and the Adolescent Health Working Group.

RESOURCES

CONFIDENTIALITY LITERATURE REVIEW SUMMARIES

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.

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.

National Association of School Nurses 2004, "Privacy Standards for Student Health Records." Available: http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNIssueBriefsFullView/tabid/445/smid/853/ArticleID/78/Default.aspx.

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 cause 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.

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.

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.

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 have 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.

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.

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.

SAM POSITION STATEMENT

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

Position

On the basis of standards of clinical practice, research findings, principles of ethics, and law, the Society for Adolescent Medicine supports the following positions with respect to confidentiality in the delivery of health services to adolescents.

- Confidentiality protection is an essential component of health care for adolescents because it is consistent with their development of maturity and autonomy and without it, some adolescents will forgo care.
- Confidential health care should be available, especially to encourage adolescents to seek health care for sensitive concerns and to ensure that they provide complete and candid information to their health care providers.
- Health care professionals should educate adolescent patients and their families about the meaning and importance of confidentiality, the scope of confidentiality protection, and the limits to confidentiality.
- Health care professionals should support effective communication between adolescents and their parents or other caretakers. Participation of parents in the health care of their adolescents should usually be encouraged, but should not be mandated.
- Health care professionals and delivery systems should review and, if necessary, revise their procedures (including scheduling, billing, and recordkeeping) to ensure that adolescents' privacy and the confidentiality of their health information are protected to the extent possible.
- Health care professionals should receive education and ongoing training to ensure that they know and understand the state and federal consent and confidentiality laws relevant to the delivery of health services to adolescents and have the skills to apply these laws when delivering clinical care.
- Laws that allow minors to give their own consent for all or some types of health care and that protect the confidentiality of adolescents' health care information are fundamentally necessary to allow health care professionals to provide appropriate health care to adolescents and should be maintained.
- Research related to confidentiality and adolescent health care should be placed within a broad research agenda focused on finding ways to increase the numbers of adolescents who receive high quality health care for the wide range of health issues important in this age group. Future research should investigate the impact of providing or limiting confidential adolescent health services on specific health outcomes, inform strategies to address system-level barriers to provision of confidential adolescent services, and define ways that health care professionals can encourage parent-teen communication without losing the trust of adolescent patients.

Background

Introduction

Confidentiality protection for adolescents' health care information is important both to adolescents and to the health care professionals who care for them. A well-established tradition has developed in the United States of making confidential care available to adolescents, particularly for sensitive concerns such as sexuality, sexually transmitted infections (STIs), substance abuse, and mental health. This tradition has been carried on by a wide variety of health care professionals in diverse settings. It is well grounded in ethics, clinical practice, and research. In addition, legal protections for confidential care have been embodied in federal and state laws [1].

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The Society for Adolescent Medicine has long recognized the importance of confidential health care for adolescents [2]. Numerous position papers of the Society have affirmed support for confidentiality in specific contexts [3–9]. In 1997, the Society published a comprehensive statement on the importance of confidentiality in adolescent health care [3].

Since the position paper on confidentiality was released in 1997, several developments have occurred that make it important and timely for the Society to issue a revised confidentiality document. New research has underscored the importance of confidential care for many adolescents. The increasing computerization of medical records and information has increased the challenges to and opportunities for protecting adolescent patients' privacy. New federal medical privacy regulations, issued under the Health Insurance Portability and Accountability Act (HIPAA), and known as the "HIPAA Privacy Rule," will have a major impact on the delivery of health services to both minors and adults.

With this revised position paper, the Society for Adolescent Medicine reaffirms the importance of confidentiality in adolescent health care and explains the support for confidentiality that is found in clinical practice, research, ethics, and law.

Clinical Practice

The overall goal in clinical practice is to deliver appropriate high-quality health care to adolescent patients, while encouraging communication between adolescents and their parents or other trusted adults without betraying the adolescent's trust in the health care professional. When deciding how best to provide confidential health care to adolescents in specific clinical situations, health care providers need to take into account the following factors:

- The patient's chronological age, cognitive and psychosocial development, other health-related behaviors, and prior family communication.
- Policies of professional organizations that often support the provision of confidential health care to minors who request privacy for a broad range of health services, including treatment of STIs, contraceptive care, outpatient mental health services and outpatient substance abuse services [10,11].
- Laws that define emancipation, determine when a minor can consent to health care (e.g., state minor consent statutes), specify when parental consent or notification is required or permitted (e.g., often for abortion services), clarify the discretion of health care professionals to disclose information, and provide guidance on access to health care information and medical records [12].
- The implications of the HIPAA Privacy Rule for the provision of adolescent health services [13].
- The limits of confidentiality (such as in situations of suspected physical or sexual abuse, suspected risk of suicide or homicide, and when public health laws require reporting certain diseases, e.g., Chlamydia, gonorrhea, TB, HIV), and strategies to involve the adolescent in appropriate plans for engaging parents or other trusted adults to assist with management of these situations.

Health care professionals must also consider a variety of practical issues. First, experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent patient alone, and by clarifying with whom the information will be shared. Beginning in early adolescence, routinely spending at least part of each visit alone with each patient conveys to the young patients and their parents that this is a standard part of adolescent health care. This also provides regular opportunities to develop a confidential relationship with adolescent patients and to discuss sensitive health topics in an open manner, and it can reassure parents that the health care professional is available to help address topics that they may have a difficult time discussing. Experiences of seasoned clinicians suggest that most parents, who are often very trusting of physicians with whom they have an established relationship, support this arrangement.

Second, routine discussions with adolescents and their parents about both the protections and the limitations of confidentiality are important. This conveys that a clinician is aware and respectful of privacy issues, educates adolescent patients and their parents about the guidelines for this aspect of care, and has beneficial effects on the patient-clinician relationship. It encourages open patient-clinician communication [14–16], which is essential for effective screening, accurate diagnosis, and risk-reduction counseling. This also increases the chance that adolescents will seek future health care for sensitive health concerns [16]. It is important to recognize that adolescent patients are attentive to the specific content of messages [16,17]. Clinicians should be as clear as possible about what can and cannot be managed privately and convey messages that adolescents both understand and can trust.

Third, clinicians need to be aware of system-level

issues that may inadvertently break confidentiality and betray an adolescents' trust. Common problems are related to billing and reimbursement procedures, scheduling notification, and privacy of medical records [18–20]. Strategies to provide appropriate confidential care within this context need to be developed where feasible [20]. Alternatively, clinicians must be knowledgeable and prepared to refer patients who need confidential services to other sites where privacy can be assured. Attention to this issue at the level of health care systems, and within the context of wide-spread use of electronic medical records, is clearly needed.

Fourth, clinicians need to learn the skills to provide appropriate confidential adolescent health care while also encouraging communication with parents. This may involve strategies such as discussing with adolescent patients their perceptions of the pros and cons of communication with parents, helping adolescents to see the potential advantages of increased communication with parents, and offering to facilitate communication with parents in a way that is helpful to the adolescent patient. Giving consistent messages to parents that health care professionals expect parents to discuss a wide range of issues related to health with their adolescent children may be helpful, and parent questionnaires may be an efficient way to regularly reinforce this message [21,22]. At the end of an adolescent visit, when "wrapping up" with the adolescent patient and the parent, it may be very useful to provide general anticipatory guidance counseling that, in fact, is tailored to needs identified during private discussion with an adolescent patient.

Finally, it is important to acknowledge that some adolescents do not have parents, parental support, or any meaningful connection with parents. Some adolescents have experienced abuse or neglect by parents, and have legitimate fears about future parental abuse, which may include being asked to leave one's home by parents [23]. When clinicians encourage adolescents to communicate openly with their parents, it is important to ask about reasons for any reluctance to do so. There are times when it may be appropriate to identify and engage other trusted adults into management plans.

Research

Over the past decade, research has confirmed that concerns about privacy can prevent many adolescents from seeking health care [16,24–28]. In two large national surveys, approximately one-quarter of middle and high school students reported that they did not seek health care they needed [26,27]. One of these studies found that 35% of students who did not seek care reported one reason was "*not wanting to tell their parents*" [26]. The impact of privacy concerns on care-seeking for specific sensitive health services is likely much higher. Essentially one-half of single, sexually active girls under 18 years of age recently surveyed in family planning clinics in one state reported that they would stop using the clinics under conditions of mandatory parental notification for prescription contraceptives. An additional 12% reported that they would delay or discontinue use of specific services such as services for STIs [28]. Subsample analyses provided an indication of the potential magnitude of negative outcomes associated with decisions to forgo care: only 1% of adolescent girls who indicated they would stop using family planning services indicated that they would also stop having sexual intercourse, instead, they would continue to have sex, but use less effective or no contraceptive methods [28]. Recent research has also confirmed that privacy concerns influence where many adolescents go for health care, and that often this is not to see their regular health care provider [24,29–31].

When adolescents do seek health care, privacy concerns likely affect the quality of health care received. A substantial proportion of primary care physicians do not provide confidential adolescent health services [32], discuss confidentiality with patients [33], or train their office staff to give accurate information about confidential services available in their practice [32]. Adolescents who are concerned about privacy are less likely to communicate openly with health care providers particularly about issues related to substance use, mental health, and sexual behaviors [16,34], which influences information exchange about key health issues for this age group [21]. Privacy concerns also influence adolescents willingness to receive services such as pelvic examinations and testing for STIs or HIV [34–37], which should be a part of routine care for many youth.

Research is beginning to document the difficulty many health care professionals face when trying to provide confidential services to adolescent patients. For example, the majority of clinician members of the Society for Adolescent Medicine note barriers to providing confidential testing for chlamydial infection in their main clinic settings, primarily related to system-level issues such as billing and reimbursement [19].

Future research related to confidentiality and ad-

olescent health care should be placed within a broad research agenda focused on finding ways to increase the numbers of adolescents who receive high quality health care for the wide range of health issues important in this age group. This should include investigating the impact of providing or limiting confidential adolescent health services on specific health outcomes, and informing strategies to address system-level barriers to provision of confidential adolescent services.

Finally, it is important to note that although research confirms the importance of confidentiality to many young people, concerns about confidentiality and disclosure of information regarding sensitive issues to parents is not universal. In the survey conducted in family planning clinics noted above [28], approximately one-third of adolescents would continue to use family planning services under conditions of mandatory parental notification for prescription contraceptive use. Previous reviews of the literature have found that most pregnant minors willingly discuss abortions with their parents [38]. Further research is needed to better understand variations in the importance of confidential health care among adolescents, and how health care professionals can facilitate improved communication between adolescents and their parents or other trusted adults in a way that benefits adolescent health and well-being [39,40].

Ethics

Protecting the confidentiality of adolescents' health information is a professional duty that derives from the moral tradition of physicians and the goals of medicine. The goals of medicine include curing disease, prolonging life, relieving suffering, and preventing illness. Basic moral principles can help guide health care professionals in their pursuit of these goals: respect for autonomy, beneficence, nonmaleficence and justice [41]. Each of these principles also has specific relevance to confidentiality protection in adolescent health care.

Respect for *autonomy* means that patients' own wishes, ideas, and choices are to be supported during the process of helping them. When a relationship exists between a health care professional and a patient that protects the patient's privacy, the patient's autonomy is supported. Protection of confidentiality in a health care setting is derived from this principle. It represents an agreement between the patient and the health care professional that information discussed with and discovered about the patient during encounters between them will not be shared with other parties without the patient's permission.

Nonmaleficence means that health care professionals avoid doing harm to the patient. In some circumstances, failing to respect an adolescent's privacy or to honor an express or implied agreement of confidentiality might cause harm. This might occur through disclosure of information to a parent or guardian, even though including parents in an adolescent's care might generally be helpful to the adolescent. Determining what may be harmful can be challenging because adolescents demonstrate different levels of maturity, engage in different behaviors, and have different family relationships. Avoiding harm, in conformity with the principle of nonmaleficence, must be viewed within the context of other moral principles such as autonomy and beneficence.

Beneficence is the principle that requires action to further a patient's welfare; doing good for the patient. Protecting confidentiality often enables a health care professional to benefit a patient. Offering confidential care to adolescent patients encourages them to disclose their symptoms and life circumstances fully and completely, thereby increasing the likelihood that they will receive appropriate care and enhancing the clinician's capacity to help them.

Justice requires health care professionals to give adolescents a fair and reasonable opportunity to receive appropriate health care on the same basis as other groups in society. To the extent that the lack of confidentiality protection impedes adolescents' access to health care they need, protection of confidentiality may be necessary to further the principle of justice.

Individual adolescents vary in their levels of psychosocial maturity and economic independence, as well as in their behaviors and family situations. Therefore, it is inappropriate to apply a single moral prescription in all cases. The protection of confidentiality in adolescent health care should be grounded in the moral principle of respect for autonomy, but must recognize that in specific circumstances it may be permissible or even necessary to breach confidentiality to further other important moral principles, such as beneficence or nonmalificence.

Both the disclosure of confidential information and the failure to disclose may constitute a clear moral breach in specific circumstances. A professional who fails to disclose confidential information, despite a likely benefit to the patient, merely because it would be inconvenient or difficult, puts his or her own needs above those of the patient. Similarly, a

professional who breaks confidentiality merely because it is "good for the patient," without a strong and persuasive reason, engages in inappropriate paternalism (i.e., interference with a person's freedom of action based on a wish to benefit them). Neither of these is morally defensible.

A breach of confidentiality, even one that is motivated by paternalism, may damage an adolescent's trust in the health care professional. Therefore, it should be avoided unless a greater good can be achieved by breaching confidentiality. There are circumstances in which breaching confidentiality by disclosing information to an adolescent's parents, caretakers, or others may lead to a greater benefit (for the patient or society). These circumstances might include cases of suicidal or homicidal ideation or acts, serious chemical dependence, and life-threatening eating disorders. "Justified paternalism" in the care of adolescents could be appropriate under these circumstances, provided there is reasonable evidence that an adolescent's capacity for exercising autonomous choice is impaired and protecting the adolescent's life is the central goal [42]. In this view, protecting life outweighs the principle of autonomy.

Even when a health care professional encounters a circumstance in which "justified paternalism" and disclosure better serve the adolescent, there is still a moral duty to respect the adolescent. This can be accomplished by explaining to the adolescent beforehand the basis of any decision to breach confidentiality and involving the adolescent in the process of identifying how and to whom the information will be disclosed.

Law

Numerous laws protect the confidentiality of health care information. Many of these laws apply to adolescents who are minors as well as to adults. Nevertheless, there are some important differences based on the legal status of adolescents. Adolescents who are under the age of majority (usually age 18) are minors and generally cannot expect the same level of confidentiality protection under the law as adults. Adolescents who are age 18 or older are adults and should expect the same confidentiality protection as other adults.

Confidentiality and consent. The concepts of consent and confidentiality are inextricably intertwined. First, when a minor's own consent for health care is not legally sufficient, the process of obtaining consent from someone else compromises confidentiality. Second, even when minors are legally authorized to consent, the law may also permit (or require) that a parent or another person or entity be informed. Third, some medical privacy laws explicitly rely on the minor consent laws in delineating who controls the confidentiality of health care information for minors.

The law generally requires the consent of a parent when health care is provided to a minor child, but includes numerous exceptions [43]. The exceptions include medical emergencies, care for the "mature minor," and laws authorizing minors to consent to their own care [12,43,44]. Consent may also be required from a legal guardian or conservator for a person who is an adult but severely mentally incapacitated.

A legal basis for minors to consent to their own care also provides a strong foundation for protecting the confidentiality of the care. Every state has statutes that authorize minors to consent to medical care under a variety of circumstances [12]. In some statutes, the authorization is based on the minor's status, such as when the minor is emancipated, married, serving in the armed forces, pregnant, a parent, or a high school graduate; is living apart from parents; has attained a certain age; or has qualified as a mature minor. In other statutes, the authorization to consent to health care is based on the type of care needed, such as contraceptive services; pregnancy related care; diagnosis and treatment of STIs, HIV, or reportable diseases; treatment for drug or alcohol problems; care related to a sexual assault; or mental health services. Although not every state has statutes covering minors in each of the above status categories or all types of "sensitive" services, every state does have some of these provisions [12]. These minor consent laws reflect policy judgments that certain minors have attained a level of maturity or autonomy that makes it appropriate for them to make their own medical decisions or that adolescents generally are unlikely to seek certain "sensitive" but essential services unless they are able to do so independently of their parents.

The HIPAA Privacy Rule. The most recent legal development affecting the confidentiality of adolescents' health care information is embodied in new federal medical privacy regulations, the HIPAA Privacy Rule, issued under the Health Insurance Portability and Accountability Act of 1996 [45]. The Rule creates new rights for individuals to have access to their protected health information and to control the disclosure of that information in some circum-

stances. It contains specific requirements that affect medical records and information pertaining to the care of minors [13,46]. The HIPAA Privacy Rule provides that, in general, when minors legally consent to health care or can receive it without parental consent, or when a parent has assented to an agreement of confidentiality between the minor and the health care provider, the parent does not necessarily have the right to access the minor's health information. Who may do so depends upon "state or other applicable law."

Thus, a health care provider must look to state or other law to determine whether it specifically addresses the confidentiality of a minor's health information. State or other laws that explicitly require, permit, or prohibit disclosure of information to a parent are controlling [13,46]. If state or other law is silent on the question of parents' access, a health care professional exercising professional judgment has discretion to determine whether or not to grant access [13,46]. The relevant sources of state or other law that a health care provider must consider include the state minor consent laws, state medical privacy laws, the federal confidentiality rules for the federal Title X family planning program, the federal confidentiality rules for drug or alcohol programs, and court cases interpreting both these laws and the constitutional right of privacy.

During the evolution of the HIPAA Privacy Rule, numerous professional health care organizations, including the Society for Adolescent Medicine, strongly supported the confidentiality protections for adolescents [47]. In its final form, the HIPAA Privacy Rule recognizes the importance of confidentiality protection in adolescent health care and allows health care professionals to honor their ethical obligations to maintain confidentiality consistent with other laws [48].

Confidentiality limits. Even when the law protects the confidentiality of adolescents' health information, legal limits apply, in addition to the clinical and ethical limits that exist. The legal limits include, for example, any requirements to notify parents in specific circumstances, laws granting parents explicit access to minors' complete medical records, legal obligations to warn intended victims of homicide and to take protective action in cases of suicidal ideation or attempts [49]. In addition, the obligation to report child abuse acts as an overall limit on the scope of confidential care, although there are ongoing questions of interpretation regarding the application of child abuse reporting laws to some adolescent health situations, such as consensual sexual behavior of adolescents [50]. Also, public health laws that require reporting of communicable diseases, including some STIs, place limits on confidentiality, although the public health reporting and contact tracing system has been structured to minimize breaches of confidentiality and to protect privacy as much as possible [51].

Confidentiality and payment. Adolescents often have difficulty obtaining confidential health care unless there is a clear way to pay for the care. Most often, an adolescent's care is paid for by parents or by health insurance. Alternatively, adolescents may be able to receive certain services without charge or at an affordable cost in a variety of settings such as community or migrant health centers, health departments, school-based and school-linked health clinics, and family planning clinics, among others [1].

A few of these sites operate under laws that provide confidentiality protection for minors as well as adults. For example, since 1970 the federal Title X Family Planning Program has included strong confidentiality protections for adolescents. In Title X clinics there are sliding fee scales based on income, and adolescents are permitted to qualify based on their own (rather than their parents') income. Eligible adolescents are also entitled to receive confidential family planning services through Medicaid and may be able to do so under the State Children' Health Insurance Program (SCHIP) [52].

Reliance on health insurance coverage for confidential care can be problematic for an adolescent. The necessity for a parent to sign the insurance claim (in the case of private insurance), or to furnish the Medicaid or SCHIP card significantly limits the confidentiality of services. Furthermore, the diagnoses on billing statements when mailed to parents can also violate confidentiality. The effect of the HIPAA Privacy Rule on adolescents' ability to obtain confidential care through a family insurance policy is not yet known, but several aspects of the Rule could be helpful [13,46]. First, the Rule gives legal significance to informal agreements of confidentiality between an adolescent and a health care provider to which a parent has given assent. Second, the Rule would permit minors who have such agreements or who have consented to their own care to request specific privacy protections from a health care provider or health plan.

Conclusion

There is a strong basis for protecting the confidentiality of adolescents' health information in the standards of clinical care for this age group. These standards are firmly supported by extensive research findings about the impact of privacy concerns on adolescents' access to care. They are also rooted in basic principles of biomedical ethics and a legal framework that has developed over nearly a half century.

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MINOR CONSENT AND CONFIDENTIALITY-RELATED RESOURCES AVAILABLE ONLINE

National Center for Youth Law
http://www.youthlaw.org

Center for Adolescent Health & the Law
http://www.cahl.org

Society for Adolescent Health and Medicine
http://www.adolescenthealth.org

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