



Consent & Confidentiality in Adolescent Health Care

A Guide for Arizona Health Care Clinicians

2018 Edition





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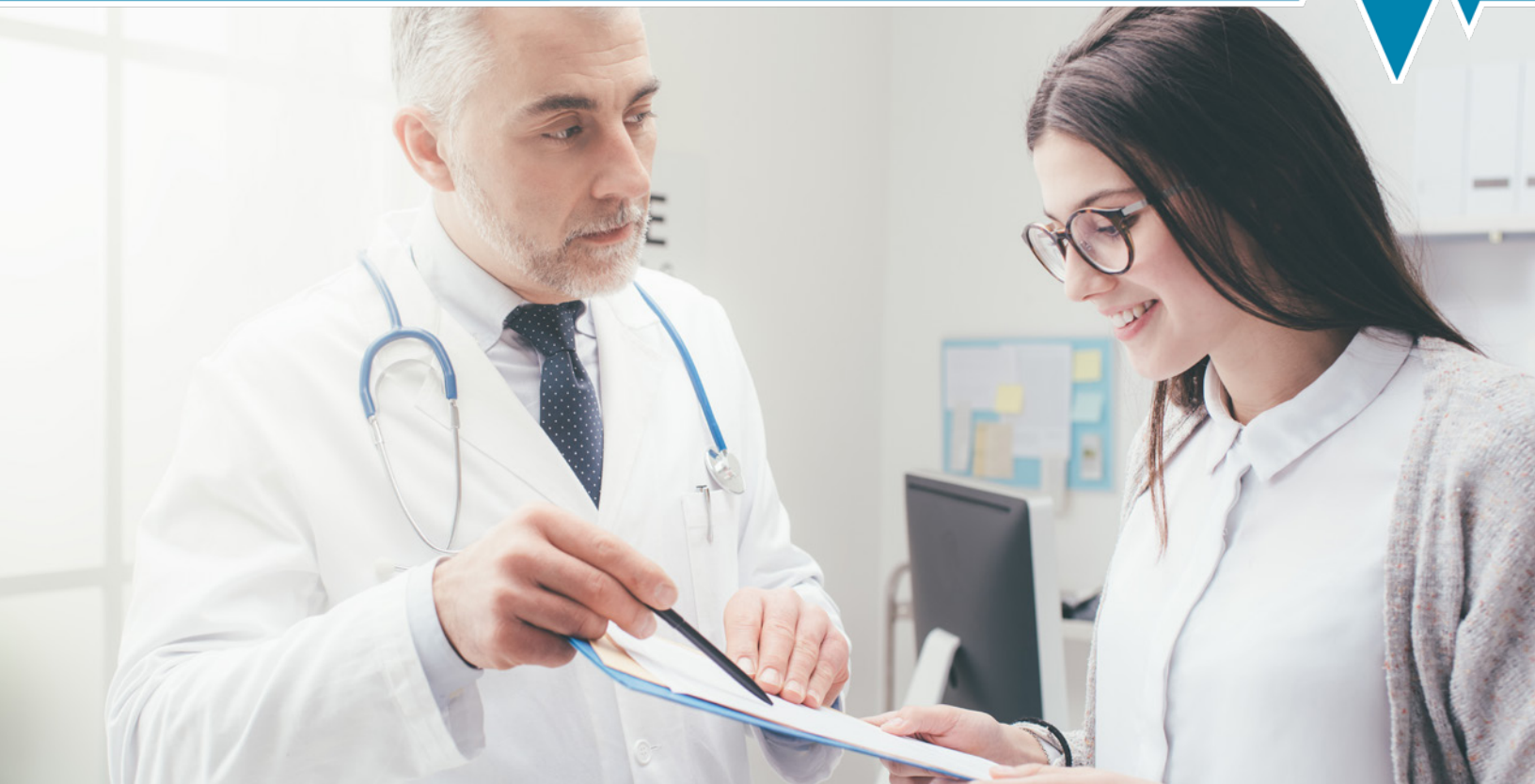
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NEEDS ASSESSMENT:

Adolescent consent and confidentiality is an area of concern in the delivery of health care to this patient population. Lack of information in this area is a barrier to optimal health care. Studies have shown that many physicians and other clinicians who deal with these issues on a daily basis are unsure of the management guidelines established for confidential care for adolescents.

TARGET AUDIENCE:

This toolkit is designed to educate all primary care clinicians and specialists who routinely care for adolescents, regarding the federal law and Arizona legal statutes that pertain to consent and confidentiality issues for this population.

PROGRAM OBJECTIVES:

This toolkit should enable the targeted audience to:

- Discuss the issues of consent and confidentiality pertaining to care of the adolescent patient.
- Describe or determine the best course of action in clinical scenarios based on State Statutes, Federal Regulations, and ethical considerations
- Develop policies and procedures for consent and confidentiality in clinicians' respective practice settings.

DISCLAIMER

This toolkit is designed to promote discussion and teach the application of the appropriate law as it relates to adolescent consent and confidentiality issues. The toolkit is not intended to serve as legal or medical advice but rather as guidelines for health care clinicians.

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Kristin Stookey is a Certified Registered Nurse Practitioner working with Arizona Family Health Partnership, the Title X Grantee for Arizona. With over 28 years of clinical experience providing reproductive health services to women, men, and adolescents, Kristin has a passion for accessible contraception to all. She has trained advance practice providers with University of Phoenix, Midwestern University, and Arizona State University. She has presented at a variety of conferences discussing contraceptive updates, STIs, reproductive life planning/pregnancy intentions, adolescent consent and coercion and Zika in the context of family planning.

Table of Contents

INTRODUCTION	7
TERMINOLOGY	7
CLINICAL GUIDELINES	8
PRACTICAL ISSUES.....	9
MANAGED CARE.....	14
HIPAA	15
A LEGAL PERSPECTIVE	16
THE LAW.....	16
EXCEPTIONS.....	16
CONSENT BASED ON STATUS	17
CONSENT BASED ON SERVICE	18
GUARDIANSHIP ISSUES	20
ISSUES OF CONFIDENTIALITY	21
CASE SCENARIOS.....	23
IDENTIFYING VICTIM OF DOMESTIC SEX TRAFFICKING	23
APPENDICES.....	32
BIBLIOGRAPHY.....	33

Introduction



Consent and confidentiality for adolescents in health care are essential and critical information. The rights of parents, adolescents and providers can be confusing and in conflict, and may result in inadequate care for these vulnerable patients. Teenagers often need to obtain confidential care for personal issues like contraceptives, diagnosis and treatment for sexually transmitted infection (STI), pregnancy, and mental health. The need for parental consent in these areas can be an enormous barrier that deters adolescents from seeking appropriate health care (Cheng, 1993).

Research reveals that teens often do not consistently seek health care they need regarding sensitive issues. The most common reason for missing care is “not wanting to tell parents” (Klein et al). In both retrospective and prospective studies it has been found that adolescents’ concerns about parental notification limit their use of health care (English, 2010). In addition, teens have reported their plans to stop using family planning clinics or delay their use of such services if parental notification is required (Ford and Beauman). Indeed, 31 percent of teens receiving care in family planning clinics do not use insurance to pay for

services because of fear of someone finding out they received treatment through billing or explanation of benefit (EOB) reporting to the parent or guardian (Frost et al 2012). In another study, only one percent of adolescent girls who indicated they would stop using family planning services if notification of their parents was required would also stop having intercourse (Reddy et al).

Although the legal system has addressed some adolescent consent and confidentiality issues, many physicians and other clinicians are unaware of federal and state legal guidelines for provision of confidential care. In addition, there are many gray areas in the law, and laws vary from state to state. Studies have shown that many primary care clinicians and medical office staff are unsure of the management guidelines established for confidential care for teenagers (Ford, Millstein). There is also a lack of consensus about confidentiality when treating adolescent patients (Fleming, Lovett and Resnick). A study of primary care physicians indicates that physicians do not consistently discuss confidentiality with their adolescent patients and do not distinguish between unconditional and conditional confidentiality (Ford, Millstein).

For those primary care and hospital clinicians who do attempt

Introduction: Terminology

to provide confidential services for adolescents, practical issues like reimbursement, compliance, communication of lab results, and release of medical records become thorny issues. Other clinical scenarios, like parental requests for drugs testing a teen without his/her knowledge, may raise important ethical dilemmas. From the teen's perspective, more than half of all adolescents want to discuss drugs, STIs, smoking, and good eating habits with their physicians (Klein and Wilson). It is clear, from this study and others, that private time with the physician is associated with increased discussions about sensitive topics and behaviors that can significantly affect their health and well-being.

When children and teens are receiving health care, the general rule is that parental consent is needed. However, there are situations when parental consent may be a barrier to receiving health care, and many professional medical organizations, as well as the law, have determined that there are exceptions to the general rule of parental consent. The American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians (AAFP), the National Medical Association (NMA), the Society for Adolescent Health and Medicine (SAHM), the American College of Emergency Physicians (ACEP), and the American Medical Association (AMA) all have policies on the provision of confidential health care for adolescents. In general, they all state that teenagers should have access to confidential services for sensitive issues, that parental participation should be encouraged when appropriate, and that the clinician's assurance of confidentiality is conditional. Of utmost importance is for the clinician to provide the best possible care for the adolescent.

This booklet is designed to educate all health care clinicians on federal law and Arizona statutes that pertain to consent and confidentiality for teenagers – when to provide confidential care. The booklet also addresses the issues from a practical standpoint – how to provide confidential care. In addition, the booklet includes ethical discussions – why provide confidential care. Case scenarios will assist in the application of the law and the “how to” of real life in a busy office, clinic, or hospital setting. This booklet is part of

a toolkit that offers a sample office policy, staff training tool, and presentation slides.

TERMINOLOGY

Adolescence

Adolescence is the required passage from childhood to adulthood that is marked by major physical changes and the development of autonomy. It can be seen as a continuum from roughly age 12 to 18 (at least by legal standards). Providing confidential care to teenagers for certain personal issues is essential to providing appropriate health care and helping them develop autonomy by encouraging them to be responsible for their own health care. In addition, by providing confidential care, the clinician can develop a trusting relationship with the teen.

Informed Consent

Informed consent means that an individual can understand the risks and benefits of the proposed treatment and treatment alternatives, and decide voluntarily whether to proceed with the physician's recommendation. Careful adherence to the usual guidelines for education and documentation of informed consent apply to adolescent self-consent. If possible, consent should be obtained from both the patient and the parents.

Implied Consent

A parent or guardian's consent may be implied consent, limited by the nature and scope of prior contacts. For example, if the parent or guardian has had contact with only one clinician or knows that the minor is assigned a single primary clinician, the consent will most likely be limited to treatment by that clinician. In a clinic setting, on the other hand, if the parent or guardian has had contact with several clinicians or otherwise knows that a single primary clinician is not assigned, then consent may include all of the clinic's clinicians. Further, consent to routine treatment may not imply consent to extraordinary care. Because the scope of implied consent is almost always uncertain, a clinician or hospital should carefully document the nature of any consent given and should seek specific consent whenever possible.

Introduction: Clinical Guidelines

Confidentiality

Confidential care means that the clinician does not reveal any information to anyone without the patient's consent. Confidential care for adolescents is important to encourage timely access to care for problems that are sensitive in nature. These concerns include sexually transmitted diseases, contraceptive care, pregnancy, mental health issues, and substance abuse. Adolescents are more willing to communicate with and seek health care from physicians who assure confidentiality (Ford, Millstein, JAMA). For this reason it is important to have some legal and ethical guidelines to provide confidential care to adolescents. Confidentiality may be conditional where the withholding of information could endanger the patient.

CLINICAL GUIDELINES

Ethically, consent can be looked at in three models (Grochowski and Bach).

Pediatric Model

In the Pediatric Model, the parents and clinician make decisions for the child's benefit with little input from the child. This model portrays no autonomy. In caring for teenagers under this model, we fail to recognize the adolescent's emerging capacity for autonomous choice.

Adult Model

The Adult Model is characterized by individual autonomy. Treatment decisions are made by the patient and clinician, and, with few exceptions, the information is kept confidential. In the health care of adolescents, this model ignores the valid interests of the parents.

Adolescent Model

The Adolescent Model is a spectrum between the pediatric and adult models. In consent and confidentiality for adolescents, this spectrum is affected by age, emotional and intellectual maturity, the relationship between the parents and adolescent, the nature and seriousness of the medical decision, legal constraints in situations involving child abuse, and problems that are sensitive in nature like STIs, contraception, and pregnancy. As clinicians, we are more comfortable with providing confidential care to adolescents

who are older, more mature, and for which the medical situation is not very serious. Confidential care becomes more concerning in young adolescents and in particularly serious medical circumstances.



Adolescent Psychosocial Development

Adolescence is a period of dynamic physical and psychosocial change. The period encompasses puberty, the sequence of physical changes that culminates in the attainment of physical maturity and reproductive capacity. Adolescence is also the developmental phase when teenagers establish their self-identities and progressively acquire the skills and competencies that will allow them to fulfill adult societal roles. During these years, teenagers adjust to their sexually maturing bodies and feelings, develop abstract thinking and decision-making abilities, establish their sexual, vocational and moral identities, and progressively achieve independence from parents as they renegotiate their relationships and parenting roles. They achieve these developmental milestones by actively exploring their environment, immersing themselves in peer culture, and developing deep friendships and intimate relationships. As adolescents navigate these years, they may engage in behaviors such as sexual activity and experimentation with drugs or alcohol that can influence their health and wellbeing.

Introduction: Practical Issues

Providers caring for adolescents have the opportunity to promote their healthy physical, psychological, and social growth and development. Parent-teen communication and parental involvement can be very beneficial in promoting positive outcomes and in caring for teenagers and should be encouraged. Clinicians need to assist teenagers and support parents through this developmental period. Studies show that compliance with oral contraceptives is higher when parents know and are involved in the health care process. Adolescents should be encouraged to include their parent(s) in health care decisions and clinicians can offer to facilitate this process. However, clinicians need to recognize that unconditional parental involvement may deter teenagers from obtaining appropriate health care.

The Society for Adolescent Health and Medicine (SAHM) recommends that clinicians “educate adolescent patients and their families about the meaning and importance of confidentiality, the scope of confidentiality protection, and the limits of confidentiality” (SAM Position Paper 2004). Confidential care can be provided to adolescents with the understanding that confidentiality will be broken if the teen has done, or is doing, something very hazardous or life threatening. This conditional confidentiality should be discussed with the teen and the parent prior to the provision of health care. Undoubtedly, clinicians may have varying measures or interpretations of what might be hazardous or life threatening depending on the clinical situation and context.

PRACTICAL ISSUES

Delivering confidential health care to adolescents can be difficult in busy practice settings, such as offices, urgent care clinics, and hospital based setting such as emergency departments. How do you address confidential concerns with the adolescent privately when they are coming in accompanied by their parents for services that require parental consent, such as well visits and sports physicals? How do you document sensitive information and confidential visits in the medical record in a manner that identifies the information or visit as confidential to prevent inadvertent breaches of confidentiality? Who can be notified of lab

results? Who can medical records be released to? What modifications to Electronic Health Records (EHR) can be made to ensure confidential adolescent care? And how can clinicians get reimbursed for appropriate medical care without parental involvement in care?



Clinicians in their respective practice settings need to educate their staff about confidentiality. Staff should be sensitive to the needs of adolescents, be knowledgeable about the specific services adolescents can consent for, and where the potential for confidentiality breaches lie. When staff, from the receptionist to the medical assistant or nurse, have a good understanding of issues related to adolescent confidentiality, they can become active participants in creating an environment that effectively supports the delivery of confidential care to adolescents. Staff awareness and understanding of this issue can be enhanced by developing policies and processes specifically addressing consent and confidentiality in adolescent health care in hospital systems and offices. Front office processes that can help support delivering confidential care include obtaining the adolescent's preferred manner of contact and contact information, in addition to that of their parents, in the event they need to be contacted confidentially. Hospital and office policies on confidentiality are also best routinely shared with parents and adolescent patients as part of the patient registration process.

Introduction: Practical Issues (cont.)



Health visits can be structured in many ways when adolescents and their parents present together. It is often most helpful to see the adolescent and his/her parent together for some portion of the visit to elicit parent concerns, obtain medical history the adolescent may not be aware of, observe parent-teen interactions, and validate the parent role. This portion of the visit also provides the healthcare provider the opportunity to discuss confidentiality policies and guidelines with the adolescent and his/her parent.

Adolescents need to be seen alone by the clinician for at least part of the office or hospital visit for any confidential care to be provided. It is recommended that clinicians begin this portion of the visit with the adolescent with a discussion of the limits of confidentiality. When sensitive services are required, it is helpful to explore with the adolescent their perspectives about involving their parents in their care while affirming their ability to access sensitive services confidentially. Parent involvement and support can facilitate aspects of care such as filling prescriptions, treatment plan adherence, and follow-up. When services such as screening for STI are provided confidentially, it is important for the clinician to review with the adolescent, and document, how they can be reached and who else can be notified of results. It is also important for the clinician to discuss with the adolescent conditions under which this information may be shared, such as situations where there is possible harm to the adolescent or others, and mandatory reporting of communicable diseases to the local health departments in the event they test positive for an STI, in which case they

may also be contacted as part of public health surveillance activities. Other potential areas for disclosure of confidential information such as Explanation of Benefits (EOB), medical records, and patient portals as discussed below should also be reviewed with the adolescent. Given these limitations to confidentiality, some adolescents may prefer to access sensitive care from federally funded family planning/Title X clinics, free clinics, and safety net programs that ensure confidentiality. It is important for clinicians to be aware of these resources in their local communities. Many adolescents choose to obtain sensitive services from their primary clinicians even after discussions of the potential limitations of confidentiality. This may indicate some openness to their parents knowing sensitive information despite their initial hesitation to include them in their care.

Prior to the implementation of EHR, strategies developed by clinicians have included writing sensitive information in code (i.e. SA for sexual activity) or on an identifiable progress note (i.e. different colored progress note, progress note marked confidential). The presence of identifiable progress notes for sensitive information or confidential visits serves to alert other clinicians of sensitive information. It also serves to alert medical records staff of portions of the medical record that cannot be released without minor consent and when release of records may need individual clinician review. In the past, some clinics have used separate “shadow” chart for the confidential information. However, the use of a shadow chart may be logistically difficult as all the medical providers in the office or clinic would need to know of its existence and

Introduction: Practical Issues (cont.)

the medical information it contains. Legally, a shadow chart is discoverable. These processes may work for clinicians still using paper charting. However, most clinicians are now functioning completely within EHR integrated systems.

Electronic Health Records (EHR)

The use of EHRs can potentially improve health care accessibility, effectiveness, and safety. EHR-based clinical decision support systems have been shown to improve care for adolescents with Attention Deficit Hyperactivity Disorder, increase human papillomavirus (HPV) vaccination rates, and reduce unnecessary antibiotic prescribing. (Co JP, Johnson SA, Poon EG, et al; Fiks AG, Grundmeier RW, Mayne S, et al; Gonzales R, Anderer T, McCulloch CE, et al). Additionally, EHRs allow patients to establish contact with their health care providers remotely and has the potential to make large amounts of population data available for health research.

The increasingly widespread adoption of EHRs and the establishment of EHR Meaningful Use regulations, however, have presented new challenges with regard to keeping medical care and medical records confidential. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the 2009 American Recovery and Reinvestment Act, offers health care systems and physicians' significant incentive payments to promote the adoption and "meaningful use" of EHRs. The Meaningful Use regulations outline core objectives required for payment for a range of EHR functions, including documenting patient problem lists and medication lists, and providing written after-visit summaries (AVSs) and discharge summaries to a target percentage of patients. Meaningful Use regulations also include providing patients with the ability to view online, download, and transmit their health information without clarifying whether the adolescent minor patient, parent or both should be included when offering access to such health information.

For an adolescent seeking confidential screening for sexually transmitted infections and contraceptive care, this information may be inadvertently disclosed to a parent through:

- Problem list, laboratory orders, or medication list imported into the health record and printed in an AVS
- Patient notes released to a parent or visible in a patient portal where the parent has full access
- Problem list, laboratory orders, test results, and medication lists that are visible in a patient portal where the parent has full access

The HITECH Act also established the State Health Information Exchange Cooperative Agreement Program, which awarded more than \$540 million to states and designated entities to ensure that mechanisms are in place to enable providers to exchange clinical information such as laboratory results and medication lists so that they follow patients as they move across various care settings (Blumenthal 2011, ARRA 2009). While Health Information Exchanges (HIE) enable more timely and complete sharing of clinical information among hospital systems and providers through data sharing agreements, they also add a layer of vulnerability to confidential health care for adolescents.

Current Recommendations for EHR Standards

The American Academy of Pediatrics and the Society for Adolescent Health and Medicine have described the lack of current EHR standards and have provided recommendations to protect adolescent confidentiality. Some recommendations for EHR standards and functionalities include:

- 1 *Functionality to designate as confidential entire visit notes (SAHM, 2014), or sensitive portions of visit notes such as social and sexual histories which may have been obtained from the adolescent privately when they present accompanied by their parents for services that require parental consent, such as well visits and sports physicals.*

Many EHR systems do not have the functionality to block out only portions of visit notes that contain sensitive and confidential information. Successful strategies employed by hospital systems and practices include developing confidential note types for adolescent sexual and

Introduction: Practical Issues (cont.)

reproductive health visits and for sensitive psychosocial information obtained privately from the adolescent.

At Arnold Palmer Medical Center in Orlando, FL, clinicians developed a confidential Adolescent Sexual and Reproductive Health note template. The note template is used to document visits where adolescents access confidential sexual and reproductive health services unaccompanied by their parents. The note template is also used to separately document sexual and reproductive health services that are delivered when adolescents present accompanied by their parents for services that require parental consent, such as well visits and sports physicals. Additionally, sensitive psychosocial information such as sexual or substance use histories obtained privately from the adolescent are documented in a confidential Adolescent Psychosocial History note template. Both note types are prevented from migrating into their patient portal to which the parent may have full access and are not released to parents without minor consent when copies of the medical record are requested.

- 2** *Functionality to designate problems, medications, laboratory and radiology orders and results as confidential, with customizable privacy controls for clinicians at the point of care. This would allow such information to be easily suppressed from an AVS, discharge summaries, or other printed material generated after a visit, as well as shielded from those who should not have access to such information. (SAHM, 2014)*

Hennepin County Medical Center in Minneapolis, MN successfully implemented this functionality by developing a Confidential visit type option at the time of patient registration and a parallel Confidential Order Set whereby laboratory and radiology orders, prescribed medications, and associated problems entered under the visit type and using the order set are prevented from being imported into the health record. This confidential information is also filtered from AVS/ discharge summaries and from the patient portal to which the parent may have full access.

At Childrens Hospital of Colorado, the health system has created the option to generate Secure After Visit Summaries (AVS) by choosing the corresponding icon in the EHR. The Secure AVS provides clinicians the option to hide diagnoses, orders, and medications associated with confidential visits by minor patients using simple Hide: Yes/No options. Clinicians are also able to preview Secure AVS prior to printing to ensure sensitive information has been filtered.

- 3** *Functionality to provide differential access to information. (SAHM, 2014). This recommendation has several different levels of applications.*

While differential access to information can be applied according to clinical role (e.g. physicians are able to see all records while scheduling staff only see demographics insurance information), it can also be viewed from the perspective of adolescents and their parents. Applied to patient portal access policies, options include: (1) permitting access to non-confidential information only to both parents and adolescents; (2) permitting full access only to 13- to 17-year-old adolescents, with parents able to receive only non-confidential information, an approach that entails actively blocking access to certain information from the parent and requires vigilance and ongoing effort to maintain, but is widely viewed by experts as the ideal; (3) permitting full parental access for unusual or complicated situations (e.g., intellectual disability or cancer), ideally customized by the adolescent; or (4) turning off portal access for all patients aged 13-17 years (Bourgeois FC, Taylor PL, Emans SJ, et al, 2008; Gray, et al. 2014).

Managing portal access status is a challenging area for many hospital systems and practices. It is important for clinicians to be aware of their patient portal access policies and their implications on confidential care for adolescents. Clinicians are encouraged to discuss portal access as a potential limitation to confidentiality if their practice settings allow both adolescents and their parents the same degree access to clinical information, which may include information related to services such as STI and contraceptive care. Additionally, clinicians are encouraged to discuss with adolescents the steps they can take to terminate parent portal access at the point of care and the potential ramifications.

At Phoenix Children's Hospital, parents of patients 12 years of age and under are invited to establish patient portal access, with only parent consent required for portal access. For adolescent patients ages 13 through 17, both parents and adolescents are invited to establish portal access, with the consent of both parties required for portal access. Adolescents are then able to access components of their medical record, with the parent having the same degree of access through a proxy account. Although note types and laboratory results designated as confidential do not migrate to the portal, records accessible through the portal may contain information such as diagnoses and medications related to sensitive services such as STI testing and treatment and contraception management that may have been provided confidentially to adolescents. Adolescent and parent proxy access to the portal is terminated when either the adolescent or the parent provides a written request to the institution's health informatics team. Unless termination is requested, both parties will have portal access until the adolescent is 18 years of age when the parent access will expire.

To prevent breaches of confidentiality, clinicians are encouraged to take the following three simple measures when delivering confidential services to adolescents ages 13-17 years.

- Determine Patient and Parents Portal Access Status as noted in the patient registration screen in the EHR
- Where both patient and parent have been invited or established portal access, discuss with adolescent patients the potential for breaches of confidentiality and the option to deactivate portal access for both parties by completing a Request to Remove Access form.
- Submit the Request to Remove Access to the institution's health informatics team who will deactivate portal access for the adolescent and parent proxy and update portal access status in the patient registration screen to indicate that access has been removed.

Clinicians are also encouraged to discuss with adolescents the implications of their parent discovering that their portal access status has been terminated and potential for parents to assume that such was at the request of the adolescent who accessed confidential care for sensitive services.

4 *EHRs should employ the same privacy protections for adolescents when transmitting health information through a HIE. (SAHM, 2014; Adler-Milstein J, DesRoches CM, Jha AK, 2011)*

As hospital systems and clinicians implement EHRs in their practice settings, it is vital that they develop mechanisms to ensure confidentiality protections for adolescents. Clinicians and health care systems must partner with EHR vendors to incorporate the technical capabilities necessary to protect adolescent confidentiality (Anoshiravani 2012). Health care providers caring for adolescents must educate vendors and purchasing institutions about existing adolescent confidentiality laws and the desirability of robust privacy settings (SAHM Position Paper, JAH, 2014). Health care providers can also help develop patient portal policies in their respective practice settings to promote and protect confidential health care for adolescents.

Medical Releases

All medical releases for adolescent patient charts should be personally reviewed by the clinician, and consent for release should be given by both the teen and his/her parent. The pertinent Arizona law will be detailed in the legal perspective section of this guide.

Reimbursement

Reimbursement adds a complicating dimension to the provision of confidential medical care to teenagers. Many people recommend charging adolescents privately for health care received without parental consent, although often insurance contracts do not allow separate billing. Charging an adolescent privately may enhance confidentiality but discourage access to health care. Using a parent's insurance for confidential care may be logistically difficult and may threaten assurances of confidentiality. It is likely to be logistically difficult to use a parent's insurance confidentially, and this should be discussed with the adolescent.

Introduction: Managed Care

Given the limitations of confidentiality regarding insurance, billing, and medical records, some teenagers may feel most comfortable with referral to a family planning clinic. This will assure confidentiality. On the other hand, when the potential limitations of confidentiality (medical records, explanation of benefits sent to parents) are described to adolescents, many of them choose to remain with their primary clinician for medical care. This may indicate some acceptance of disclosure to parents despite initial hesitation to include parents in their health care.

MANAGED CARE

Managed health care is affecting confidential health care of adolescents in a variety of ways. Low co-payments allow teenagers easier access to confidential health care than the old fee-for-service programs. Promotion of and coverage for preventive care encourages establishing a medical home, identifying a primary care clinician, and developing a trusting patient-clinician relationship. This will enable adolescents to disclose sensitive information that affects their medical care.

On the other hand, when an explanation of benefits (EOB) is sent to parents, assurances of confidentiality may be breached. In addition, even low co-payments may be a financial barrier for some teens. The referral system requirements of most managed care companies also cause problems for confidential care.

Such issues raise many questions. Can the provider request that the insurance company withhold an EOB to protect confidentiality? Do the HMOs, PPOs, etc. currently have policies on confidential health care for teenagers? Do they provide financial access to safety-net providers in the community? Can clinicians bill teenagers separately to ensure confidential care or is this not allowed under the clinician's managed care contract?

A recent SAHM position paper on Managed Care states that "managed care arrangements should incorporate protections for adolescents to receive confidential care and procedures allowing adolescents to give informed consent for their own care, as allowed by state and federal law."

Generally, managed health care companies in Arizona do not have policies on confidential health care for teenagers, and they have no specific protections or procedures for confidential care and adolescent informed consent. To our knowledge, none will allow the suppression of individual EOBs that would breach confidentiality. The ability to suppress individual EOBs relating to specific sensitive medical issues would enhance the ability of the clinician to provide confidential care.

When managed care companies threaten confidential adolescent health care with EOBs, some clinicians have historically skirted the problem by billing adolescents directly or referring them to family planning clinics. Unfortunately, managed care contracts do not allow patient billing for covered services. In addition, they do not cover safety-net clinicians, like family planning clinics, for teenagers. Although the care at family planning clinics is usually provided at a discounted rate, it may be cost prohibitive for many teenagers.

Managed care companies need to develop policies and procedures on the provision of confidential health care for adolescents addressing the issues of EOBs, safety-net clinicians, parental access to medical records, & referral processes.



Introduction: HIPAA



HIPAA

The HIPAA Privacy Rule (Health Insurance Portability and Accountability Act of 1996) is a federal medical privacy regulation that creates rights for individuals to have access to their protected health information (See 45 C.F.R. § 160.). In addition, individuals can control the disclosure of their health care information in some circumstances.

With input from the Society for Adolescent Health and Medicine (SAHM) and other professional organizations interested in adolescent confidential health care, HIPAA addresses the issue of confidentiality for minors and their medical records. According to HIPAA, the parent does not necessarily have the right to access the minor's health information if the teen can legally consent to the health care or the parent has assented to an agreement of confidentiality. Under these circumstances, who may have access to the adolescent's health records depends on "state or other applicable law" (SAHM Position Statement 2004).

This rule "embodies important protections for minors, along with a significant degree of deference to other laws

(both state and federal) and to the judgment of health care providers" (English 2004). In this way the rule has allowed a compromise between the importance of parental knowledge and participation in the teen's health care and the important availability of confidential health care services for the teen.

Since there is no single Arizona statute that deals specifically with the confidentiality of a minor's medical record on the issue of parental access, the clinician can use his/her professional judgment regarding release of records, or at least the confidential aspect, to parents. If the teen can consent to care based on the type of care (STIs, emergency care, etc) or their status (emancipated, married, etc), the individual adolescent and not necessarily his/her parent has the right of access to their health information. This is also true if the parent has agreed to confidentiality between the health care provider and the teen. According to the SAM Position Statement, "In its final form, the HIPAA Privacy Rule (2002) 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."

A Legal Perspective: The Law

THE LAW

For the purposes of medical care, a minor is a person under 18 years of age. Generally, a minor may not give valid consent to the performance of a medical or surgical procedure upon his or her own body. The consent of a parent or guardian is usually required. Possible statutory exceptions to this rule are discussed below.

Specific consent is needed when health care providers are going to penetrate the skin, insert or implant something in the body, use radiation, or do surgery or comparable invasive procedures which interfere with body tissues. In general, no one may perform surgical procedures on a minor without first obtaining the written consent of the parent or legal guardian, except in the case of an emergency when such procedure is necessary for the treatment or serious disease, injury or drug abuse, to save the patient's life, or where the parent or legal guardian cannot be found after a reasonably diligent effort (A.R.S. § 36-2271). Obtaining consent is required for injections and recommended for examinations of patients' bodies where there are special privacy concerns. (Such consents do not take the place of a nurse or other appropriate witness if pelvic or breast examinations are to be done for physically mature minors.) The consent of a parent or guardian is required for vaccinations given to minors (A.R.S. § 32-1974(M)).



EXCEPTIONS

In general, a minor may be given medical care only if a parent or guardian gives actual consent or the treatment involves emergency medical care and the parent is unavailable for consent. The minor may consent if one of the following conditions apply:

- The minor is emancipated, married, or homeless (A.R.S. § 44-132);
- The care relates to sexually transmitted diseases (A.R.S. § 44-132.01);
- The care relates to rape or sexual assault and the minor is 12 years of age or older (A.R.S. § 13-1413);
- The care relates to alcoholism (A.R.S. § 36-2024);
- The care relates to substance abuse and the minor is 12 years of age or older; (A.R.S. § 44-133.01) or
- The care relates to HIV testing (A.R.S. § 36-663).

In each case, the underlying facts for the application of these criteria should be documented in the medical record at the time of treatment. When a condition permitting the minor to consent is satisfied, the minor should sign the consent forms applicable to the treatment. Due to the minor patient's relative immaturity and inexperience, time needs to be spent to confirm that the consent is informed and adequate.

The law governing treatment of minors has numerous exceptions and nuances; this summary will focus on the most common issues and is not meant to be exhaustive. It does not address more case-specific problems related to extremely immature minors who may lack mental competence to consent, the court-ordered treatment of minors, or discuss in detail the rights of minors to refuse medical care. In all circumstances, if physicians and hospitals use common sense and their best judgment, with an emphasis on what is best for the patient, and document their thought process, the liability risk will be minimized.

In addition to Arizona law, numerous regulations also exist which apply to adolescent health care. A regulation is an authoritative rule or order having the force of law which is issued by an executive body. Regulations relating to health

A Legal Perspective: Consent Based on Status

care for minors come from diverse sources and include, for example, Title X Family Planning regulations, which are issued by both the federal Department of Health and Human Services (HHS) and state family planning agencies, confidentiality regulations for drug and alcohol treatment programs (issued by HHS), and regulations concerning contagious diseases, STIs, and HIV (issued by state health departments).

In general, with a few exceptions relating to alcohol and substance abuse, if the minor is able to consent to treatment, then the minor should also have the right to see and consent to disclosure of his or her records. In such circumstances, records and information should not be shared with parents unless the minor consents.

Be consistent. Consent and confidentiality are issues that are generally tied to one another. If a decision is made to allow a minor to consent to treatment, information concerning that treatment should be held in confidence unless otherwise specified by law.

CONSENT BASED ON STATUS

Emancipation

An emancipated minor is commonly viewed as an individual who lives away from the parent, is free from parental control, and is self-supporting. By statute, an emancipated minor is defined as a person who is at least sixteen years old, a resident of Arizona, is financially self-sufficient, and is neither under a legal duty of service to his or her parent nor entitled to that parent's support under Arizona law (A.R.S. § 12-2451). For those who are living free of parental control or are self-sufficient, there must be a judicial ruling for the minor to be legally emancipated. Attending school out of state would not, for example, indicate emancipation if the parent/guardian remains the child's source of support. A minor in the military or one who is married is also considered emancipated. An unmarried pregnant minor or an unmarried minor parent are not considered emancipated.

Homelessness

A minor can consent to medical care if he or she is homeless, although homelessness is often difficult to document. To be

homeless the minor must live away from parents and lack a fixed and regular night time residence or live in a supervised shelter designed to provide temporary accommodations, a halfway house, or a place not normally used for sleeping by humans.

Mature Minors

While not mentioned in Arizona Statute, you may hear the phrase "mature minor" used when deciding to provide care outside of the parent/guardian's consent. This common law concept is based on an opinion by the U.S. Supreme Court, which states that rights do not "come into being magically only when one attains the state-defined age of majority" (Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 74;1976).

Under this doctrine, and particularly in areas affecting reproduction and related medical care, mature minors are felt to be able to consent for their own care. Because some courts have been willing to apply the mature minor doctrine in cases that have resulted in litigation, liability for providing treatment without parental consent to a mature minor is mitigated.

Obviously, very young adolescents would not ordinarily be considered "mature." With adolescents nearing the age of majority, some record should be made of the reason for deciding that the patient is or is not "mature" enough to consent to a particular course of treatment. However, recognize that there is not a legal definition of "mature minor," nor is it recognized under Arizona law. Other jurisdictions have found the minor to be "mature" when:

- He or she is 15 years old or older and is able to understand the risks and benefits of the proposed care sufficiently well to give an informed consent; and
- The medical care is for the patient's benefit; and
- The care is necessary according to conservative medical opinion; and
- There is good reason (including the minor's objection) for not obtaining parental consent.

(The above is not a legal definition.)

A Legal Perspective: Consent Based on Service

CONSENT BASED ON SERVICE

Emergencies

When rendering emergency medical, surgical, hospital, or health services, efforts should be made to secure consent from a parent or guardian, but emergency care should not be unduly delayed. If the minor's condition could deteriorate, treatment should begin at once and consent should be sought concurrently. Although "emergency" can be defined either broadly or narrowly, it clearly has a broader meaning than just "life threatening." As in most cases, determining when to treat emergencies without parental or guardian consent requires good judgment and common sense. Physicians or hospital personnel should document efforts to contact the parent or guardian to secure consent to emergency care.

Sexually Transmitted Infections (STI)

A minor may consent to evaluation of, and treatment for, STI without notice to a parent or guardian.

Sexual Assault

A minor 12 years old or older may consent to treatment for sexual assault if it is not possible to contact the parent or guardian due to the short period of time available before examination and treatment is necessary. As always, clinicians must report all sexual assaults to either law enforcement or the Arizona Department of Child Safety.

Pregnancy

There are no specific Arizona statutes addressing the right of minor parents or pregnant minors to consent to their own health care. In the absence of such a statute, however, a pregnant minor can generally receive care under the "mature minor" doctrine or on an emergency basis. Thus, a pregnant minor would generally be able to consent to treatment for her pregnancy—including prenatal care, delivery services, treatment of complications, and postnatal care. It is interesting to note that under Arizona law an adolescent mother has the right to consent for her child's medical care, but not her own medical care unless she is emancipated. There have been no Arizona cases specifically testing the use of the mature minor doctrine in Arizona.



Family Planning Services

Two areas where federal law and regulation weigh heavily include family planning services and issues concerning abortion. The federal Title X Family Planning Program has assured confidential access to contraceptives and other family planning services for teens for nearly four decades. Title X services must be made available without regard to age and on a confidential basis. Federal law does require that Title X Programs encourage family involvement, but parental notification or consent is not required.

The above provisions generally do not govern clinicians who are not participants in a Title X program. Although no Arizona statute specifically addresses family planning, an opinion issued by the State Attorney General in 1977 states that a minor may consent to family planning services (Ariz. Op. Att'y Gen. No. 77-37; 1977). The opinion also states that a health care provider who delivers such services will not be civilly or criminally liable to the minor's parents for battery. The clinician would be well advised to consider and document evidence of the maturity of the minor when providing such services without parental consent.

Abortion Services

The U.S. Constitution protects the right of privacy for minors as well as adults. This right of privacy has been expanded to encompass decisions concerning not only contraception, but also abortion. The issue of parental involvement when pregnant minors seek abortions has been the subject of

A Legal Perspective: Consent Based on Service

much controversy and many court cases in the past 25 years. A state may require parental consent only if it provides an alternative procedure under which authorization may be obtained.

Under Arizona law, a person may not perform an abortion on a pregnant unemancipated minor unless the physician has obtained written, notarized consent from one of the minor's parents, guardians, or conservators, or unless a judge authorizes the physician to perform the abortion (A.R.S. § 36-2152). Parental consent is not required if the pregnancy resulted from sexual contact with the minor's parent, step-parent, uncle, grandparent, sibling, adoptive parent, legal guardian, foster parent or an unrelated male living with the adolescent and her mother. Additionally, no parental consent is needed if the attending physician, on the basis of the physician's good faith clinical judgment, certifies in the minor's medical record that the abortion is immediately necessary to avert the minor's death or an irreversible impairment of major bodily function.

Emergency Contraception

For emergency contraception such as Plan B, Ella, or their generic equivalents, parental consent is not required. The medication is available over the counter without age restriction, and both men and women may purchase the product.

Alcoholism and Substance Abuse

A minor may apply for care to an approved treatment facility, but family must be notified as promptly as possible if the minor is admitted for treatment. An adolescent 12 years of age or older who is found to be under the influence of a dangerous drug or narcotic (including withdrawal) may be considered an emergency case and should be regarded as having consented to care needed for treatment. In these instances, the additional consent of the minor's parents or guardian is not necessary to authorize hospital or medical care.

Drug Testing

There is no applicable Arizona statute that states the minor must be aware of, and consent to, drug testing requested by

a parent or guardian. In a narrow sense, based on Arizona law, the knowledge or consent of the minor probably is not necessary. However, this is one of many circumstances where the clinician has an opportunity to foster open communication and positively impact family dynamics. Parents requesting such tests to "confirm their suspicions" should be queried as to what they intend to do if results are positive and counseled about the impact of the secrecy on the eventual welfare of the minor.

HIV Testing

A minor's capacity to consent to HIV testing is based on his or her ability to understand and appreciate the nature and consequences of the test, regardless of the minor's age. Therefore, the parent's consent will not always be necessary if the test is to be given to a mature minor. Because of the ramifications of this test, the clinician or other qualified provider should determine the capacity of the minor to consent. Capacity to consent means ability to understand and appreciate the nature and consequences of, and make an informed decision regarding, a proposed service, treatment or procedure.

The Centers for Disease Control and Prevention (CDC) recently revised recommendations for HIV screening to include the following (See "HIV Testing," Centers for Disease Control and Prevention, available at <https://www.cdc.gov/hiv/guidelines/testing.html>):

- Conducting routine, voluntary HIV screening for all persons ages 13 to 64 in any health care setting, regardless of risk.
- Screening all patients with tuberculosis (TB) or seeking treatment for STI.
- Repeating annual HIV screening of all persons with known risk.
- Opt-out HIV screening with the opportunity to ask questions and the option to decline testing.
- Communication of test results in the same manner as other diagnostic/screening test.

A Legal Perspective: Guardianship Issues

Additionally, the CDC does not recommend requiring separate signed informed consent or prevention counseling in conjunction with HIV screenings in health care settings.

Mental Health Treatment

Under a 2010 Arizona law (A.R.S. § 36-2272, see Appendix C), health care clinicians – as well as “any “person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities” – may not perform mental health screenings of a minor in a non-clinical setting or perform mental health treatment on a minor without the prior written or oral consent of the minor’s parents or legal custodian. If consent is given through telemedicine, the clinician must verify the identity of the parent or the custodian at the site at which consent is given. These consent requirements do not apply in the event of an emergency that requires a screening or treatment to prevent serious injury to or save the life of a minor child.

If an examination of the adolescent patient raises concerns that there might be mental health issues, then an assessment of whether referral might be necessary is recommended. The health care clinician does have the right to ask questions, interview and educate all patients regarding mental health concerns or issues.

Refusal of Consent by the Minor

If a competent minor refuses care, then strong consideration should be given to the minor’s wishes. Mature minors, if competent, have been allowed to refuse care in some situations. However, when parents or legal guardians consent, the physician should normally comply with parental instructions that are consistent with the patient’s best interest. It is generally easier to defend the giving of appropriate care than to defend someone who has harmed a patient by not giving sufficient care.

GUARDIANSHIP ISSUES

Minors in Custody

Minors in the custody of the juvenile court, department of youth treatment and rehabilitation, or in the physical custody of someone other than the natural or adoptive parent cannot be hospitalized for evaluation or treatment without approval

by the court upon application filed by the child’s probation officer, parole officer, caseworker, or attorney.

Minors with Stepparents

If a minor has been legally adopted by a stepparent, the stepparent may consent to the performance of medical or surgical care upon the minor. If a minor has not been legally adopted by the stepparent, the stepparent generally may consent if the biological parents are unavailable. Health care personnel should proceed carefully if there is a disagreement between the minor’s biological parent and adoptive stepparent.

Minors with Legal Guardians

If the minor is in the care and custody of a legal guardian, the guardian may consent to the minor’s care. The clinician should require the consenting party to show proof of guardianship. A certified copy of the court order establishing guardianship should be attached to the signed consent form.



Minors of Divorced or Legally Separated Parents

Generally, the consent of either parent is legally sufficient. However, where parents of a minor patient are divorced or legally separated, an attempt should be made to obtain the consent of the parent who has legal custody of the minor. This is especially true if divorced or legally separated parents disagree about the performance of a particular treatment. Difficult cases should be discussed with counsel.

A Legal Perspective: Issues of Confidentiality

Treatment when Parents Disagree

Generally, the clinician is not obligated to seek consent of both parents. However, if it becomes apparent that there is a disagreement between natural parents, it is wise not to act in the absence of an emergency or without a court order authorizing treatment. Upon application, a court may order performance of a medical procedure or surgery on the minor where a stalemate between the parents would otherwise prevent it. Such situations require the input of counsel or your facility risk manager.

Persons with Temporary Care of a Minor

The right to consent can be delegated by the parent or guardian to another person who temporarily has care or custody of the minor. Such delegation should be in writing, using some sort of “continuing consent to treatment of minor” form. Practically speaking, every effort should be made to contact the parent or guardian if the minor is very ill and/or requires serious treatment or surgery.

ISSUES OF CONFIDENTIALITY

Medical Records

Generally, in Arizona, an individual’s medical records and the information contained in them are privileged and confidential. There is no single Arizona statute that deals specifically with the confidentiality of a minor’s medical records. Rather, several statutes determine a health care clinician’s rights and duties regarding the confidentiality of a minor’s medical records.

A health care clinician may only disclose this information pursuant to law or the written authorization of the patient or patient’s health care decision-maker, which includes the parent of a minor. The Arizona Parents’ Bill of Rights also confirms a parent’s right to access and review all medical records of their minor children, unless prohibited by law or when the parent is the subject of an investigation for a crime against the minor (A.R.S. § 1-602(6)). Arizona statutes, however, also allow a patient to limit access to his or her medical records. Thus, in some situations, Arizona law may be interpreted to give minors the right to limit their health care decision-maker’s access to the minor’s medical records and

prohibit a health care clinician from giving these records to the minor’s health care decision-maker. Even when minors choose to limit access to medical records and information, they need to understand this is not absolute. Special reporting statutes or simple cost of care issues may impact the ability to keep the adolescent’s health care information confidential.

Communicable Disease

Regardless of the patient’s age, clinicians are required to report communicable diseases to the Arizona Department of Health Services (ADHS; Arizona Administrative Code Title 9, Chapter 6). The adolescent should be made aware of reporting requirements, just as with their adult counterparts. Under Arizona law, information regarding communicable disease is highly confidential. Release of information in such circumstances is tied to the patient’s capacity to consent more than it is to his or her majority. If a minor has been determined to be mature or by law otherwise capable of consent, information or records concerning the communicable disease should not be released without the patient’s consent, even to a parent or guardian unless by order of the court or other administrative body.

Duty to Report

Arizona law directs that any physician or other person having responsibility for the care or treatment of children immediately report “or cause to be reported” to a peace officer or to the Department of Child Safety if that individual’s observation or examination of any minor discloses reasonable grounds to believe that a minor is or has been the victim of non-accidental injury, sexual abuse, molestation, sexual exploitation, incest, child prostitution, death, abuse or physical neglect (A.R.S. § 13-3620). Arizona law does not allow a minor to consent to sexual activity with anyone aged 18 years or older (A.R.S. § 13-1405).

A clinician does not have to report a minor’s evidence or report of sexual activity if the sexual activity involves minors age 14 through 17 and there is no evidence that the sexual activity was anything other than consensual.

Arizona law makes it a felony for an adult to engage

A Legal Perspective: Issues of Confidentiality



knowingly in sexual conduct with a minor less than 15 years old; it is a lesser felony if a minor is 15 or older. Although there is no statute or case that obligates providers to ask their minor patients about the age of their sexual partner, a clinician must report consensual oral sex or sexual intercourse with a minor under age 18 whose partner is 18 or older or 13 or younger as sexual abuse. Exclusions that might prevent prosecution and therefore taken into consideration include the following: if the activity was consensual, the victim is age 15, 16, or 17 and the defendant is less than 19 years of age; or the defendant is attending high school and is no more than 24 months older than the victim.

The statute also requires that the person who has custody or control of the minor's medical records make either the records or a copy of the records available to the investigating peace officer or Department of Child Safety's worker upon presentation of a written, signed request.

Noncustodial Parents

Arizona law states that the noncustodial parent is entitled to have access to medical records or other information unless otherwise provided by court order or law, or if the court finds that access would "seriously" endanger either the child's or the custodial parent's physical, mental, moral, or emotional health (A.R.S. § 25-403.06). The premise behind the statute is that the noncustodial parent is entitled to equal access to documents, including medical records and other

information regarding his or her child's physical, mental, and emotional health. It follows that noncustodial parents have no greater rights than custodial parents, thus the same statutes discussed above seem to limit noncustodial parents' rights to obtain their minor child's medical records and the information contained therein.

Cost of Care Considerations

For other than emergency care, the ability to consent may have consequences for patient confidentiality related to, and payment for, the cost of care. Parents or guardians are liable for the cost of care provided to a dependent where the minor has a right to consent without consulting the parents. When minors are accessing sensitive services outside of their insurance coverage as dependents, each minor needs to be informed that he or she may be responsible for paying for services, and appropriate arrangements should be made.

Use of Best Judgment

A clinician who has carefully considered and clearly documented his or her thought process in providing care believed to be in the minor's best interest will be in a good position to defend his or her actions.

Hopefully, this section has acquainted you with the applicable laws and regulations to assist you in making the informed decisions needed to care for your adolescent patients. Clinicians, as always, are responsible for erring on the side of best medical judgment for an individual patient's welfare.

Case Scenarios

Case 1 – Immunizations

Susan, 15, a long-standing patient of yours, is an excellent student and active in volleyball. Her mother drops her off for her sports physical and she plans to take the bus home. As her primary care physician, you do a full checkup and determine she needs a Tdap, HPV, and MCV4.

Can Susan consent to the immunizations without parental consent?

Legally, in Arizona, Susan cannot consent to the immunizations without parental consent unless she is emancipated. Susan does not meet the emancipation requirements since she lives with her parents, is not free from parental control, and is not self-supporting. Although Susan may be considered a mature minor for this procedure, there is no mature minor statute in Arizona. Therefore, legally, parental consent is required.

While the HPV vaccine can be interpreted as prevention and treatment of STI, it is important to note that current legal statutes in Arizona, as well as federal guidelines, specifically require parental consent for immunizations. Choosing to administer HPV to an adolescent without parental consent and under the auspices of STI treatment could open a health care worker to liability issues and charges of battery.

Ethically, Susan is mature enough to understand the risks and benefits of the immunizations. In addition, the shots are for her benefit and the risks are very low.

Practically, there are many ways to obtain parental consent in this situation. Your office should have Susan's mother sign a general form in early to mid-adolescence giving general consent for medical care; however, this would not fulfill the requirement of use of the Vaccine Information Statement (VIS) with each immunization. Your office staff may ask Susan's mother to come in prior to the visit to review the VIS and give consent, or the information and consent can be faxed prior to or during the appointment.

Case 2 – Release of Medical Records, Contraceptives, Sexual Activity

Jennifer, 15, comes in with her mother for evaluation of a persistent headache. When interviewed alone she reports recent sexual activity. She has had one partner and is using condoms most of the time. Her last normal menstrual period was last week. She doesn't want her mother to know, but she would like oral contraceptives. She also needs routine screening for sexually transmitted diseases. She is on a PPO with a \$30 copay. You know that her parents will receive an Explanation of Benefits from her insurance for the visit and lab tests.

Can she consent to her own care? What do you do about reimbursement?

Legally, Jennifer can consent for testing and treatment of a sexually transmitted disease. Since she can consent, the medical care can remain confidential.

Regarding the contraceptive care, the Arizona Attorney General opined in 1977 that no clinician would be held criminally or civilly liable for providing family planning services to a minor without parental consent.

Ethically, it is important to provide these confidential services so that Jennifer will develop a trusting relationship with her clinician, feel comfortable disclosing this information in the future, and obtain the appropriate medical care. The need for parental consent in this situation may be a significant barrier to obtaining medical care.

Practically, although clinicians routinely provide family planning services to teens without parental consent, compliance can be greatly enhanced by parental participation. You may encourage Jennifer to include her mother in this important health care decision, and you may offer to facilitate the discussion. You may also describe the reimbursement options. Jennifer may choose to pay for her care, or she may accept insurance billing with the understanding her parent(s) will receive an explanation of benefits from the insurance company. For some teenagers, a referral to a family planning clinic may be more acceptable.

Case Scenarios

Case 3 – Drug Screening & Drug Abuse

Until a few months ago, Jason, 16, did well in school and was active in student government. His parents notice that his grades have since deteriorated, he has started skipping school, he has changed his dress and friends, and has been avoiding his family. His mother made an appointment for a checkup and asked your staff to perform a urine drug screen without Jason's knowledge. You see Jason alone and he denies using substances other than infrequent marijuana use. His physical exam is normal. From this history, appearance, and demeanor, you are worried about drug abuse.

What is the Arizona law relative to testing Jason's urine for drugs?

Legally, there is no Arizona statute that addresses the issue of a minor's consent to (and therefore knowledge of) drug testing. In a narrow sense of the law, the knowledge or consent of the minor is not necessary in Arizona. Laws vary tremendously from state to state on this issue. Strictly speaking, in this situation, the parents have a legal right to the results.

Ethically, to enhance a trusting relationship between the clinician and the teen and to promote the teen's developing autonomy, a drug screen should generally not be done without the teen's knowledge and consent. There may be instances where clinicians need to deliberate whether involuntary testing is in a patient's best interest. Deciding what is in a patient's best interest depends on many factors including age, emotional, and intellectual maturity, the relationship between the parents and the teen, and the nature and seriousness of the medical decision.

Practically, the clinician needs to discuss the issues of drug use and signs of abuse with the family and with Jason. What are the parents or the clinician going to do with a positive result from a urine drug test done without Jason's knowledge or consent? What will they do with a negative test? The negative test does not rule out substance use, and confronting Jason with a positive result will show him that he cannot trust his parents or the clinician. Jason's recent behavioral changes indicate a problem without the drug screening, and some type of mental health evaluation and treatment for Jason and his family is indicated.

Case 4 – Depression

Sam, 16, comes in to a school-based clinic for chronic abdominal pain, with his parents having provided general consent for school-based health services at the start of the school year. His usual excellent grades have dropped and he has had trouble sleeping. When you interview him alone you find that he is markedly depressed although he denies previous or current thoughts of suicide. You recommend outpatient mental health assessment and counselling as a next step. Sam is reluctant for you to share information about his depression with his parents.



Can Sam consent for outpatient mental health assessment and counselling?

Legally, Arizona law generally requires parental consent for outpatient psychological treatment or counseling of minors. However, this requirement is waived in the event of an emergency requiring mental health screening or treatment to prevent serious injury or to save the life of a minor child. Parental consent is also required for inpatient care.

Ethically, although Sam is a relatively older teen by age, his depression is significantly impacting his health and academic performance and he is not able to receive the appropriate care without parental involvement. Every effort should be made to encourage communication between the clinician, Sam, and his parents. Exploring with Sam the reasons behind his reluctance to share this information with his family

Case Scenarios

while emphasizing the benefits of involving his family could be important in this situation to help build a trusting relationship. While close follow up to reassess for potential suicidality which would mandate parental involvement is warranted, the clinician is not required to involve his parents against Sam's wishes at this time as he does not report acute suicidality.

Practically, Sam needs mental evaluation and treatment. He cannot consent for this service and he will need to involve his family to provide consent for him to receive the appropriate treatment. Because he does not report acute suicidality or pose an immediate threat to his life and safety, the clinician is not required to make his family aware of Sam's depression should Sam refuse this. Nevertheless, the clinician should strongly encourage involving his family and explore with Sam the reasons behind his reluctance to share this information with his family and emphasize the benefits of involving them, including being able to receive needed care. Additionally, the clinician should ensure close follow up and reassess for potential suicidality which will warrant parental involvement. Clinicians need to carefully weigh the risks and benefits of involving parents in such cases and err on the side of patient safety and wellbeing.

Case 5 – Drug Use

Sally, 16, is being seen for a well checkup. She is a cheerleader and in student government. Her grades are excellent. Her parents report no problems when interviewed. Alone, Sally reports occasional use of marijuana and alcohol with her friends. She denies riding in a car with someone high, using drugs or alcohol to relax or feel better, using them alone, or forgetting things while using. Her family and friends have never mentioned that she should cut back and she has never been in trouble because of alcohol or drugs. She has no signs of depression or suicidal ideations. She denies other drug use. She is dating someone, but denies sexual activity.

How do you counsel her? Can you keep the confidentiality you promised?

In this scenario, Sally displays all the characteristics of substance use and experimentation and not substance abuse. The clinician may discuss the risks of these drugs and the problems of good decision-making while under the

influence – driving, sexual abstinence, trying other drugs, etc.

Legally, Arizona law requires parental consent for mental health treatment of minors.

Ethically, Sally is an older teen who appears mature. Confidentiality could be important in this situation to encourage her to take responsibility for her own health and to help build a trusting relationship.

Practically, clinicians are encouraged to discuss confidentiality and its limits with adolescents. Each clinician's yardstick measurement of life-threatening behavior may be different, depending on factors such as patient's age and clinical context. In this case, Sally's behavior does not appear to be life-threatening at this time. Assuring confidentiality at this time may be appropriate. If problematic substance use becomes an issue in the future, parental involvement may be indicated.

Case 6 – STI Treatment

Rachel, 14, is a new patient brought in by her mother for complaints of abdominal pain for several weeks. After obtaining an initial history from mother and Rachel together, you see Rachel by herself and begin by discussing with her confidentiality and its limits. You learn that she has been sexually active for more than six months without any contraception. For the last week, she has been experiencing moderate to severe pelvic pain. You suspect pelvic inflammatory disease (PID).

You perform the pelvic exam and confirm PID. You determine that outpatient treatment is appropriate. Rachel relates that her parents are strongly opposed to premarital intercourse and have indicated stern disapproval of such behavior. She would like for you to keep her information about her diagnosis and treatment confidential and expresses concern for her safety should her parents find out.

What do you do?

Legally, Rachel can consent to her care without parental consent because it relates to a sexually transmitted disease.

Ethically, Rachel is a relatively young teen by age and she

Case Scenarios



may require the involvement of her parents to adhere to recommendations for treatment and follow up. Every effort should be made to encourage communication between the clinician, Rachel, and her parents. Acknowledging the reasons behind her reluctance to share this information with her parents while emphasizing the benefits of involving her family could be important to help build a trusting relationship.

Practically, the clinician needs to be sure that Rachel receives the appropriate medical care and follow up. It is important for the clinician to assess with Rachel her ability to fulfill important aspects of treatment such as obtaining prescribed medications and making it to follow up appointment/s. It is also important for the clinicians to emphasize the benefits of involving her family where she is unlikely to be able to adhere with treatment recommendations without their involvement.

Alternatively, the clinician can ask her to identify other supportive adults who can be involved in her care or attempt close medical follow-up before notifying the parents if Rachel proves unable to do so without their involvement.

Given Rachel's concern for her safety if her parents find out about her diagnosis and treatment, it is important to discuss with her potential threats to confidential care for sensitive services such as Explanation of Benefits and patient portal access. Assist her in developing a safety plan should she find herself in an unsafe situation should such inadvertent breaches of confidentiality occur.

Clinicians need to err on the side of best medical judgment for an individual's welfare.

Case 7 – Emergency Care and Ectopic Pregnancy

Beth, 17, presents to your emergency department with a three day history of right-sided pelvic pain that has become severe. Her last normal menstrual period was eight weeks ago. She is sexually active and uses contraception intermittently. A positive pregnancy test and an ultrasound exam confirm your suspicion of an ectopic pregnancy. She needs emergency surgery and her parents are not available.

Can you provide the emergency care without parental consent? When parents are available, is their consent required?

Legally, physicians can render emergency medical and surgical care without parental consent when obtaining consent would delay appropriate medical treatment. Efforts should be made to obtain parental consent, and these efforts should be documented.

Other than the statute regarding abortion, Arizona has no specific statute addressing the right of pregnant minors to consent to their own health care. If parents are available, their consent is necessary for the care.

Ethically, Beth is an older mature teen who is consenting to an emergency procedure that benefits her.

Practically, you need to provide the best possible medical care. This is an invasive procedure and her parents or legal guardian will need to be notified and will have legal right to obtain her medical records.

Case 8 – Sexual Assault

Becky, 14, is brought to your emergency department by the local police for evaluation of sexual assault. She reports being raped three hours previously, and she needs to be evaluated. She is worried about getting pregnant and would like the morning after pill. Her parents are out of town and she is staying with her 18-year-old brother, who does not have authority to consent to her medical care.

Can you examine her and treat her for injuries without parental consent? Can she consent to the morning after pill to prevent pregnancy?

Legally, a minor 12 years old or older may consent to treatment for sexual assault if it is not possible to contact the parent or guardian due to the short period of time available before examination and treatment is necessary.

For emergency contraception, an over-the-counter medication, parental consent is not required.

Ethically, she is an early adolescent. However, timely treatment is for her benefit and in her best interest.

Practically, emergency contraception is offered in the emergency department setting as a standard of care for sexual assault.

Following any unprotected intercourse, both men and women can purchase emergency contraception without any age restriction, or a prescription. Pharmacies might keep emergency contraception behind the counter. While administering emergency contraception within 72 hours is most effective, studies show effectiveness up to 120 hours (Glasier, et al; Fine, et al).

Case 9 – Pregnancy

Molly, 15, is referred to you (an obstetrician) for care during her pregnancy. She is at 16 weeks gestation at her first visit and has had no previous prenatal care. She lives with her parents, and she wants to keep the baby.

Can you provide Molly with routine obstetrical care with only her consent?

Legally, Molly does not fit the criteria for an emancipated minor in Arizona. In this circumstance, most providers would rely on the mature minor doctrine to guide them. However, the mature minor doctrine is not contained either in Arizona case law or statute. To reduce the risk associated with utilizing this doctrine as the basis for treatment, the factors for assessing consent used by courts in other states, should be fully documented in the medical record:

- The minor is 15 or older ;
- The nature of the care;
- The care is beneficial;
- The care is necessary; and
- There is a good reason for proceeding without parental consent.

Ethically, Molly appears to be mature and the care benefits her and the baby.

Practically, Molly needs good prenatal care. Despite the lack of an appropriate Arizona statute, the routine obstetrical practice in Arizona is to allow for the adolescent to consent for her own prenatal care and all related treatments. This is consistent with other areas of the United States, and it is the standard of care.

Case 10 – Guardianship

Robert, 12, is brought in for an earache and fever by his babysitter. He is a longstanding patient of yours whom you know well. There is no formal parental documentation in the chart that allows the babysitter to give consent for medical care.

Can you examine and treat Robert for this minor illness?

Legally, parental consent is required for treatment of Robert's minor illness and attempts should be made to reach Robert's parents. Documentation should be made of those attempts in the medical record.

Ethically, since you know the family and since this is a minor illness, you should examine and treat Robert even if you are unable to reach his parents for consent.

Practically, families should provide general written consents for the chart for other individuals to give consent for medical care. A parent can also send a written note with Robert or the babysitter indicating consent for medical care. Your office staff should attempt to contact one of Robert's parents for oral consent, which if received, needs to be documented by two staff members.

Case 11 – Abortion

Angie, a 16-year-old patient, arrives with her boyfriend, with the complaint of "flu symptoms." Her parents have completed a general consent form.

After completing your exam, you tell Angie that her "flu symptoms" of nausea and fatigue are likely due to an early pregnancy. The test confirms your diagnosis of pregnancy. After explaining her options, you elicit a promise that she will return in two days to discuss what she has decided. You strongly encourage her to involve a parent in her decision.

Angie does return for follow-up. At this time, Angie wants an abortion; she reports that she consulted her parents and it has not gone well.

Can you continue to provide medical care without the consent of her parents?

Legally, if she decides on an abortion, Arizona law requires the consent of a parent or a judicial bypass.

Ethically, it is important to recognize Angie's emerging autonomy while being mindful of the benefits of parental involvement and support.

Practically, you can counsel her, offer her a couple referrals, and give her information to contact a judge as soon as possible to obtain judicial consent if she decides she wants an abortion.

Case 12: Confidentiality, Electronic Medical Record, and Patient Portals

Janet is a 17-year-old transgender female who presents for a well visit. She is accompanied to the visit by her father and they deny any new health concerns since her last health supervision visit almost two years ago. When interviewed alone, she discloses that she has engaged in oral and receptive anal intercourse with two male lifetime partners and uses condoms inconsistently. You strongly recommend comprehensive screening for pharyngeal and rectal chlamydia and gonorrhea, HIV, and syphilis. She agrees to your recommendations but would like for this information to be kept confidential.

While your health system has developed EHR functionalities to designate diagnoses, laboratory orders and results as confidential so they do not appear on the current after visit summary, your EHR system does not have the functionality to prevent this information from being imported into the patient portal. You determine that both Janet and her parents have shared access to the patient portal.

Can you keep this confidential? How do you proceed?

Legally, Janet can consent to her care without parental consent because it relates to a sexually transmitted disease; therefore, she also controls the release of information related to this service.

Ethically, Janet is a relatively older teen and her medical care is not serious at this time.

Practically, you need to be able to contact Janet if any of her screening tests return positive. Obtaining and documenting her contact information, who else can be contacted with results, and through what mechanism at the time of the visit are key to delivering confidential care. You document clinical information related to screening for STIs and her sexual history in a confidential Adolescent Sexual and Reproductive Health Visit note, separate from the Adolescent Well Visit note. You discuss with her the potential for breaches of confidentiality and the option to deactivate portal access for both her and her parents by completing a request to terminate portal access which she completes.

Case 13: Parental Refusal for Care

Liam is a 17-year-old who checks in to your ED with an ankle sprain, accompanied by his girlfriend. He wants it evaluated. He lives with his parents and is a senior in high school. Registration calls his parents and speaks to his mother, who refuses treatment.

Can Liam consent for treatment of his ankle injury?

Legally, he does not fit any criteria for being emancipated nor is his care emergent. Legally, you cannot continue care.

Ethically, Liam has a non-emergent problem that does not require treatment at this time.

Practically, you could speak to the parent by phone to understand her reluctance to consent to treatment. This will allow you an opportunity to assess for any concerning family issues. The RN who performed the triage on Liam can provide advice to pursue care with the involvement of his parents. When minors and guardians disagree about their treatment, it is important to carefully document.

Case 14: Domestic Minor Sex Trafficking (DMST)

An adolescent girl presents to ED with vaginal discharge and pain. She looks and acts like a young teenager. She was brought in by her “aunty” who said that they would pay cash for the visit. The aunty answers all of the history questions. You interview your patient privately, beginning with a discussion of confidentiality and its limits. She says she is 15 and doesn’t go to school. She states that she has had

unprotected sex. During your exam, you find a tattoo of the name “Alex”, bruising on the left breast and the right upper back, and a thick green vaginal discharge. She denies being a victim of sex trafficking.

Do you need to contact the authorities?

Legally, healthcare providers are mandated reporters for minors who are suspected victims of sexual abuse or exploitation.

Ethically, this teenager is a victim, even if she doesn’t think she is, and needs help to extricate herself from her abusive situation.

Practically, after the social worker evaluation, you both agree that there are several red flags for Domestic Minor Sex Trafficking and you call the local PD. Getting this child the resources she needs will help treat her immediate medical issues (STIs, physical abuse, need for contraception) and may encourage her to find safety. For various reasons, these adolescents may return to their abusive or exploitative situations numerous times before they make the choice to seek safety. However, it is important to offer advice, resources, and potential solutions when concerns for sex trafficking are identified.





Identifying Potential Domestic Minor Sex Trafficking Patients

Initial Presentation:

- Accompanied by domineering adult who does not allow child to answer questions
- Accompanied by an unrelated adult
- Accompanied with other children and only one adult
- Variable information regarding demographics
- Chief complaint may be acute sexual or physical assault
- Chief complaint is suicide
- Child is poor historian for age or disoriented from sleep deprivation or drug intoxication
- Can't describe where he/she is staying, doesn't know city

Historical Findings:

- Multiple STIs
- Previous pregnancy / abortion
- Frequent visits for emergency contraception
- Chronic runaway behavior
- Chronic truancy or problems in school
- History of sexual abuse / physical abuse / neglect
- Involvement of child protective services
- Especially foster care or group home

- Juvenile justice history
- Significantly older boyfriend
- Substance use / abuse
- Lack of medical home, frequent ED visits

Physical Findings:

- Evidence suggestive of inflicted injury
- Tattoos: Sexually explicit; A man's name; Gang affiliation; Bar code
- Withdrawn, fearful
- Signs of substance abuse
- Expensive items (jewelry, clothing)
- Hotel keys
- Large amounts of cash
- Poor dentition
- Obvious chronic lack of care

Helpful screening questions:

- Has anyone ever asked you to have sex in exchange for something wanted or needed (money, food, shelter, or other items)?
- Has anyone ever asked you to have sex with another person?
- Has anyone ever taken sexual pictures of you or posted such pictures on the internet?

Case 15: Title X Family Planning Services

Katie, 14-years-old, and her sister, Madison, 16-years-old, come into your clinic for birth control. They come without parents or partners. They both agree to “be examined together” for moral support. Financially, they qualify for “no charge services” based on income eligibility.

The limits of confidentiality are explained and neither client is being forced to have sex or coerced into doing something that isn’t consensual.

After discussion of the various methods of contraceptives available, Katie chooses oral contraceptives and Madison a contraceptive implant. Madison has been with her partner for “a really long time” and is scheduled to have her contraceptive implant inserted with her next menses. Katie leaves with multiple packets of oral contraceptives.

Can Katie and Madison consent for these services?

Legally, reproductive health services provided at a Title X funded health center must be confidential. Although family involvement is encouraged, parental consent is not required. It is not necessary to inquire about the age of the partner(s) unless it is your agency’s policy to do so.

Ethically, Katie and Madison are acting as responsible adolescents to prevent an unintended pregnancy.

Practically, Title X funded clinics are a good resource for confidential care for noninsured and underinsured individuals as well as teens or minors who are seeking sensitive services outside of their insurance coverage as dependents.

Case Scenario 16: Addiction

Jordan is a 13-year-old female who is being seen at your ED for abdominal pain. She is accompanied by her grandfather, who is her legal guardian. She was seen six days prior with abdominal pain, nausea, vomiting, and diarrhea. A full work up for an acute abdomen was performed at that time. You are suspicious of drug use and that her symptoms are consistent with drug withdrawal. You obtain a urine drug screen (UDS), which is positive for opiates. She eventually confidentially admits to heroin abuse for the past three months. You determine that she needs emergent medical stabilization followed by outpatient addiction treatment. Her grandfather does not know about her drug abuse.

How do you proceed?

Legally, there is no Arizona statute that addresses the issue of a minor’s consent to (and therefore knowledge of) drug testing. In this scenario, drug testing was done as part of her emergent medical evaluation. Being an emergent situation, the consent of Jordan’s grandfather would not be required for her to receive emergent care if he was unavailable to provide consent, but should be obtained where possible. His consent, however, would be required for her to access mental health counseling for substance abuse. As her legal guardian, her grandfather also has a legal right to the results.

Ethically, Jordan is a young teen with a serious potentially life-threatening problem. In this case, the right thing to do would be to inform the guardian and work toward assistance for her drug addiction. A psychosocial evaluation would also be appropriate to ensure that she is safe in her grandfather’s care.

Practically, while Jordan can receive emergency care, she will not be able to access mental health counseling for substance abuse without involvement of her legal guardian, her grandfather.

Appendix A: Additional Resources

Arizona Chapter, American Academy of Pediatrics (AAP): www.azaap.org

Centers for Disease Prevention & Control (CDC): www.cdc.gov

Center for Adolescent Health and the Law: www.cahl.org

Adolescent Health Working Group (AHWG): www.ahwg.net

Society for Adolescent Health and Medicine (SAHM): www.adolescenthealth.org

Appendix B: Arizona Revised Statute 26-2272

36-2272. Consent of parent required for mental health screening or treatment of minors; exception; violation; classification; definition

A. Except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining the written or oral consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given.

B. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

C. A person who violates this section is guilty of a class 1 misdemeanor.

D. For the purposes of this section, "parent" means the parent or legal guardian of a minor child.

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