



Consent & Confidentiality in Adolescent Health Care

A Guide for Arizona Health Care Clinicians

— 2026 EDITION —

Arizona Chapter

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NEEDS ASSESSMENT

Consent and confidentiality are critical considerations in caring for adolescents. Studies show, however, that many clinicians may be unfamiliar with federal and state statutes that outline the specific health services that adolescents may consent to without parental involvement and how to keep information pertaining to these services confidential.

TARGET AUDIENCE

This toolkit is intended for primary care clinicians and specialists who care for adolescents.

PROGRAM OBJECTIVES

Readers of this toolkit should each be able to:

- Discuss the importance of confidentiality in adolescent healthcare.
- Describe adolescent development and its implications on emerging autonomy and capacity for informed decision-making.
- Apply knowledge of federal and Arizona state laws, along with ethical and practical considerations, in the clinical care of adolescents.
- Develop policies and procedures with minor consent and confidentiality protections consistent with federal and state laws and best practices for their respective practice settings.

DISCLAIMER

This toolkit is designed to provide an overview of federal and Arizona state laws relevant to minor consent and confidentiality in adolescent healthcare, highlighting key provisions and their practical implications. The toolkit presents guidelines and best practices and is not intended to serve as legal or medical advice.

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Introduction



Adolescence is a developmental stage of dynamic physical and psychosocial change. It encompasses puberty, the sequence of physical changes culminating in physical maturity and the attainment of reproductive capability.

Along with these physical changes, adolescents tackle important developmental tasks through which they acquire the skills and competencies that will allow them to fulfill adult societal roles and expectations.¹ They establish their sexual, vocational, and moral identities that shape their values, beliefs, and aspirations. Adolescents also develop abstract thinking, reasoning, problem-solving, and decision-making skills crucial for navigating their transition into adulthood. During this period, they gradually gain autonomy and independence from their parents or caregivers, reshaping their relationships and familial roles. Adolescents achieve these developmental milestones by actively exploring their environments, immersing themselves in peer culture, and developing deep friendships and intimate relationships.

Clinicians caring for adolescents play a crucial role in fostering their healthy physical, psychological, and social development. Adolescence is an important formative stage when patterns of health behaviors are formed. From negative behaviors such as smoking and substance use to positive behaviors such as maintaining high levels

of physical activity, adolescents often carry the health behaviors they form during these years into adulthood where they will affect rates of acute and chronic disease and life expectancy. As they explore the world around them, adolescents may engage in risk behaviors, such as sexual activity or experimenting with drugs and alcohol, which can affect their health and well-being.

Adolescents require tailored approaches that account for their developing skills and growing autonomy while addressing their specific needs. Although positive parent-teen communication and parental involvement can act as powerful protective factors and should be encouraged, unconditional parental involvement may discourage teens from openly discussing sensitive matters or seeking necessary care.

As such, minor consent for sensitive services and confidentiality protections are a cornerstone of adolescent health care.² Ensuring adolescents have access to confidential care is essential for fostering an environment where adolescents feel safe to have open and honest conversations and seek the care they need.³ Trusting relationships and confidentiality protections enable clinicians to better engage their adolescent patients, learn about their specific concerns, screen for risk behaviors as part of routine health supervision, deliver tailored preventive guidance, and offer resources and referrals for care.

Research indicates that adolescents value confidentiality highly and are more likely to engage in meaningful

conversations with their clinicians when they feel assured that their privacy is protected. Research also suggests that adolescents frequently avoid seeking health care for sensitive needs primarily because they do not want to inform their parents and caregivers. In retrospective and prospective studies, concerns about parental notification have been shown to significantly restrict adolescents' use of health care services and can significantly deter adolescents from seeking appropriate health care.^{4, 5}

Major medical organizations - including the American Academy of Pediatrics (AAP), the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), and the Society for Adolescent Health and Medicine (SAHM) - have each articulated position statements and practice guidelines that support minor consent and 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. Federal and state statutes also allow minors to provide consent for specific sensitive services and to access care confidentially.^{6, 7, 8}

Many clinicians, however, may be unaware of the specific health services minors may consent to and access confidentially based on federal and Arizona statutes. The legal landscape can be ambiguous and varies across states. Studies have shown that clinicians and office staff frequently lack knowledge about management guidelines for confidential adolescent care.⁹ Additionally, there can be a lack of consensus among clinicians regarding the need for confidentiality in treating adolescents.¹⁰ Clinicians often do not consistently discuss confidentiality with adolescent patients, nor do they adequately distinguish between unconditional and conditional confidentiality.⁹ Recognizing the intersecting rights of parents and adolescents while managing professional and ethical responsibilities can sometimes be confusing and conflicting, and ethical dilemmas may arise. When providing confidential care, clinicians often encounter practical challenges that present the potential for breaches, especially in managing electronic health records, granting portal access, releasing of health information, and completing the Explanation of Benefits (EOB) reporting process. These factors potentially compromise the quality of care adolescents receive.

This monograph is designed to serve as a practical guide for clinicians on federal laws and Arizona statutes related to minor consent and confidentiality in adolescent care. It addresses legal, ethical, and practical aspects of providing care to minors, aiming to clarify ambiguities and improve access to quality care for adolescents. Case scenarios are included to illustrate key concepts and their application in

clinical practice. The monograph also offers resources for patients and families to support the delivery of confidential care in healthcare settings.

Adolescent Psychosocial Development

Adolescence is a transitional stage between childhood and adulthood. In addition to experiencing the sequence of physical changes of puberty resulting in physical maturity and the attainment of reproductive capacity, adolescents navigate significant psychosocial change as they work through attaining specific developmental tasks. The developmental tasks of adolescence can be broadly categorized along the domains of identity, social, emotional, cognitive, and moral development. Adolescents are a widely heterogeneous group and their progression through these tasks does not occur in a linear, uniform manner. Their progression is incremental and interdependent in nature and occurs in the continuum of 3 phases:

- › **Early adolescence:** 11 to 13 years/middle school years
- › **Middle adolescence:** 14 to 18 years/high school years
- › **Late adolescence:** 19 to 21 years/post-high school graduation or college years

Identity Development: As they explore various aspects of themselves and their place in the world, adolescents progressively form their sexual, vocational, and moral identities that shape their values, beliefs, and aspirations. By exploring distinct roles, relationships, interests, and beliefs, adolescents integrate different facets of their identities into a unified and authentic sense of self.



Emotional Development: Early adolescence can be a time of emotional changes, with heightened emotions and mood swings. While a normal part of development, these can be potentially challenging for adolescents and those around them. As they mature, adolescents become more aware of their own emotions and those of others. This increased emotional intelligence allows them to develop empathy, navigate social relationships more effectively, and better understand the complexities of their feelings.

Social Development: Adolescence involves navigating complex changes in social relationships with family members, peers, and other adults. Relationships with family members undergo changes as adolescents seek greater independence and autonomy. Conflicts can sometimes arise as adolescents challenge parental authority, assert their own values and beliefs, and establish their own agency. Peer relationships deepen and become increasingly important and often serve as their primary source of support and influence. Adolescents may find themselves in intimate relationships, providing a context for them to explore their identity and gain social skills. Additionally, adolescents often begin to establish relationships with other adults outside their families, such as teachers, mentors, and coaches. These relationships can provide guidance, support, and opportunities for personal growth. Navigating these varied social dynamics is crucial for developing interpersonal skills, emotional regulation, and a sense of belonging and identity within their social world.



Cognitive Development: Adolescents experience significant gains in their cognitive abilities, including improvements in abstract thinking, reasoning, problem-solving, and decision-making skills. They begin to think more logically and systematically about complex issues. They can more adeptly consider hypothetical situations, understand abstract concepts, and engage in higher-order thinking processes. Their ability to plan for the future, evaluate the consequences of their actions, and think critically about their own thought processes also becomes more pronounced. These cognitive advancements enable adolescents to better understand and navigate the increasingly complex social, academic, and personal challenges they encounter as they transition toward adulthood.

Moral and Ethical Development: Adolescents progressively form their own moral and ethical viewpoints, influenced by their expanding cognitive abilities and social experiences. They start to critically evaluate societal norms and develop a personal sense of right and wrong.

An understanding of adolescent psychosocial development helps clinicians tailor their approach and communication to match the adolescent's maturity level and ensure that the care provided aligns with their developmental capacities and needs. Clinicians caring for minors accessing services confidentially must also assess adolescents' cognitive development and their capacity for abstract thinking, reasoning, and decision-making, which are important for processing information related to their health care. This involves assessing whether the adolescent comprehends the nature of the medical services, the potential risks and benefits, and the implications of their decisions.





Terminology

Informed Consent

Informed consent is the process by which clinicians discuss the details of a proposed treatment with a patient or legally authorized representative.¹¹ The details discussed include reviewing risks, benefits, and alternative treatments. Individuals must display competence for decision-making and understanding of a proposed treatment and must decide voluntarily whether to proceed with the recommendation for informed consent to be documented.

Implied Consent

Implied consent refers to when a patient's actions or behavior suggests they agree to a treatment or procedure without explicitly verbalizing their consent. This usually happens when the patient demonstrates a clear understanding of what the treatment entails and proceeds in a manner that indicates acceptance. For example, if a clinician explains a procedure to a patient and the patient then presents themselves for that procedure or follows through with the necessary steps to receive it, their actions can be interpreted as consent. While implied consent may be appropriate for routine care where the risks and implications are minimal, complex or invasive procedures require explicit consent where the patient provides clear verbal or written agreement.

Assent

Assent pertains to the informed consent of a minor patient obtained alongside parental consent. With the minor patient present, the discussion on whether to proceed with a specific treatment recommendation includes the details, benefits, and risks of a recommended treatment along with alternative treatments tailored to the patient's developmental and cognitive state.¹¹

Confidentiality

Confidentiality refers to the protection of privileged and private information shared during a health care encounter and in medical records that document the encounter.¹² It relates to the control of, access to, and disclosure of health information.

Sensitive Services

Sensitive services are categorized as health care services related to sexual and reproductive health, mental health services, and alcohol and substance use-related treatment. Sexual and reproductive health services include contraceptive care, pregnancy-related care, prevention, diagnosis and treatment of sexually transmitted infections (STIs), and examination and treatment after sexual assault.

Health Information Exchange (HIE)

Health Information Exchange (HIE) is the mobilization of health care information electronically across organizations within a region, community, or hospital system. HIE provides the capability to electronically move clinical information among different healthcare information systems.

Clinical Guidelines

Ethically, consent can be viewed through three distinct models.¹³

Pediatric Model:

In the Pediatric Model, decision-making is largely driven by the parents or legal guardians, who act in the best interests of the child. The child's autonomy is often overlooked, with decisions made without significant input from the child. This model is most appropriate for very young children who lack the cognitive and emotional maturity to participate meaningfully in medical decisions.

Adult Model:

The Adult Model emphasizes the autonomy of the individual, with the patient taking an active role in making their own treatment decisions. Confidentiality is maintained between the patient and clinician, with exceptions in rare cases. While this model prioritizes patient autonomy, it may overlook the legitimate concerns of parents, especially when the patient is a minor.



Adolescent Model:

The Adolescent Model represents a balanced approach to healthcare decision-making that takes into account the unique developmental stage of adolescence. Adolescents are at a critical juncture where they are gaining the cognitive, emotional, and moral capacities to make decisions but may still rely on the support and guidance of their parents or guardians. This evolving capacity for autonomy can make healthcare decision-making more complex compared to the Pediatric or Adult Models.

In this model, decision-making is viewed as a continuum. Younger adolescents may require more parental involvement, while older adolescents, particularly those with higher levels of maturity, may be afforded greater autonomy in making health care decisions. Clinicians play a crucial role in assessing the adolescent's capacity for autonomous decision-making by considering factors such as:

- **Age:** Adolescents closer to adulthood are generally given more autonomy in decision-making.
- **Maturity:** Emotional and intellectual maturity varies between individuals, and clinicians must assess whether the adolescent can understand the consequences of their medical decisions.
- **Nature of the decision:** The seriousness of the medical issue also influences the level of autonomy given. For minor or routine decisions, greater autonomy may be appropriate, whereas life-threatening or complex decisions may warrant more parental involvement.
- **Legal considerations:** Laws regarding the age of consent and confidentiality in medical decision-making differ by jurisdiction and must be adhered to by clinicians.

Balancing confidentiality with the need for parental involvement is essential in promoting the adolescent's well-being.

When possible, clinicians should strive to empower adolescents to make informed choices about their care while also encouraging open communication with their parents or guardians, especially when dealing with more serious health issues.

This approach respects the adolescent's growing independence while recognizing that parental support can be critical to the overall success of their health care.



Practical Considerations

The Office Environment

Adjusting the office environment to support confidential care for adolescents involves creating a space that ensures privacy, fosters trust, and effectively manages sensitive information. It is important to ensure that all staff members are educated about confidentiality and are sensitive to the unique needs of adolescent patients so they can be active participants in creating an environment that effectively supports the delivery of confidential care to adolescents. Staff must be knowledgeable about which services adolescents can consent to without parental involvement, how to manage and protect sensitive information, and how to handle situations where confidentiality might be at risk. Developing clear policies on minor consent and confidentiality and ensuring that these policies are well-communicated and easily accessible to staff can also significantly enhance the support provided to adolescent patients. Clearly communicating office policies with parents and adolescent patients as part of the patient registration process and reinforcing them through visible posters and handouts can further promote transparency and trust.

Regularly updating and verifying contact information for the adolescent and their parent(s), combined with implementing secure communication methods such as encrypted messaging or secure online portals, is essential for maintaining confidentiality and ensuring effective communication with adolescent patients.

Ensuring that the physical environment in which adolescents receive care feels safe and supportive is of equal importance. Specific strategies include providing adolescents with separate areas where they can complete screening questionnaires away from their parents and guardians, ensuring that examination rooms are soundproof and that conversations cannot be overheard in the waiting areas or hallways, and using privacy screens in shared spaces to create visual barriers to enhance confidentiality.

The Visit

How do you address concerns with the adolescent privately during visits for services that require parental consent and attendance, such as well-visits and sports physicals? Health visits with adolescents and their parents can be structured in a number of different ways. It is often helpful to see the adolescent and their parents together for the initial portion of the visit prior to spending time alone with the adolescent to elicit concerns, obtain medical history the adolescent may not be aware of, observe parent-teen interactions, and validate the parent role. This part of the visit also gives the clinician the chance to discuss confidentiality policies and guidelines with the adolescent and their parents.

Alternatively, visits can begin with time alone with the adolescent before including their parents. Some visits might require clinicians to visit separately with each to best focus on their specific concerns without the influence of the other party's presence.

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 protections, and the limits of confidentiality.”¹⁴ Clinicians should explain confidentiality and its limits at the outset of care, both to the adolescent and their parent or guardian. The approach ensures that everyone understands the scope of what will remain private and what circumstances warrant disclosure, promoting trust in the clinical relationship.

The concept of conditional confidentiality emphasizes balancing the adolescent's right to privacy with their safety and well-being. While most conversations with adolescents can be kept confidential, exceptions exist in situations where their actions may pose serious harm to themselves or others. The threshold for what may constitute serious harm can indeed vary, as clinicians may interpret risks differently. Each situation should be assessed individually, considering the adolescent's unique context and the potential consequences of maintaining versus breaching confidentiality. Clinicians should use their professional judgment, guided by legal and ethical standards, to make these decisions.

Adolescents are ideally seen alone by the clinician for at least part of the visit to review recommended screenings and identify questions and concerns they may wish to discuss in private. It is recommended that clinicians begin this portion of the visit by reiterating the limits of confidentiality with the adolescent.

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 autonomy and ability to access sensitive services confidentially without parental involvement. Parental involvement and support can facilitate aspects of care such as filling prescriptions, treatment plan adherence, and follow-up.

When sensitive services such as screening for sexually transmitted infections (STIs) are provided confidentially, it is important for the clinician to verify with the adolescent and document how they can be contacted and who else can be notified of results or needed follow-up. It is also important for the clinician to discuss the conditions under which their information may be shared. This includes situations where there is serious harm to themselves or others and the mandatory reporting of communicable diseases to the local

Practical Considerations

health departments for positive STI/HIV results, 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, 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. Clinicians should also be aware that the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, does not send EOB to subscribers, which prevents this type of confidentiality breach.

Electronic Health Records (EHR)

Electronic health record (EHR) systems have gained widespread acceptance and use and have become integral to the health-care industry. EHRs provide clinicians with immediate access to comprehensive patient information that can facilitate better-informed clinical decisions, improve coordination of care across different care settings, and reduce delays in care. EHR-based clinical decision support systems have been shown to improve care for adolescents with attention deficit hyperactivity disorder (ADHD), increase human papillomavirus (HPV) vaccination rates, and reduce unnecessary antibiotic prescribing.^{15, 16, 17} EHR systems can also enhance patient and family engagement as many systems include patient portals that allow individuals to access their health information, schedule appointments, request prescription refills, and communicate with their clinicians.

The widespread adoption of EHRs and Meaningful Use regulations, however, have presented challenges in keeping medical care and associated records confidential. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the 2009 American Recovery and Reinvestment Act, offered health-care systems and clinicians significant incentive payments to promote the adoption and “meaningful use” of EHRs.

The Meaningful Use regulations were implemented in stages, with specific objectives and criteria focused on various aspects of EHR functionality, including:

- **Patient Problem Lists:** Maintaining an updated list of patient problems.
- **Medication Lists:** Keeping an active list of medications.
- **After-Visit Summaries (AVSs):** Providing summaries that include relevant health information and instructions after each visit.
- **Discharge Summaries:** Ensuring patients receive comprehensive information upon discharge.
- **Patient Access to Health Information:** Providing patients with the ability to view online, download, and transmit their health information. The regulations do not specify whether the adolescent minor patient, parent or both should be included when offering access to such health information.¹⁸

While the Meaningful Use regulations provided a framework for improving EHR functionality and patient engagement, they created vulnerabilities in access to health information and privacy for adolescents. For an adolescent seeking confidential screening for sexually transmitted infections (STIs) and contraceptive care, for example, this information may be inadvertently disclosed to a parent through:

- Problem lists, laboratory orders, medication lists imported into the health record and/or printed in an after-visit summary, or visible in a patient portal where the parent has full access.
- Visit notes 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.^{18, 19} While Health Information Exchanges (HIEs) enable more timely and complete sharing of clinical information among hospital systems and clinicians, they also add a layer of vulnerability to confidential health care for adolescents due to broader access through comprehensive data-sharing agreements.

The 21st Century Cures Act of 2016 (Cures Act), a federal law signed in December 2016 designed to provide patients with better access and control over their electronic health information (EHI), presents additional challenges to maintaining privacy and confidentiality for adolescent

patients.²⁰ A 2020 rule issued by the Office of the National Coordinator for Health Information Technology (ONC) established compliance requirements and timelines for implementation of 21st Century Cures Act provisions. The ONC Rule requires that patients have immediate access to their EHI, including medication lists, laboratory results, and clinical notes, other than psychotherapy notes. Additionally, the ONC Rule requires sharing information between the patient and their healthcare site and across sites through HIEs. The ONC Rule also contains a ban on “information blocking,” defined as a practice that interferes with access, exchange, or use of electronic health information except as allowed by law or covered by an exception.^{21, 22, 23} Individuals and entities violating the ban on information blocking could face significant civil penalties and other disincentives.

The ONC Rule contains eight exceptions to the information-blocking ban, three of which are especially relevant to adolescent healthcare:

- 1. Infeasibility Exception:** This exception applies when it is technically impossible to separate confidential information from shareable information. In situations where a minor’s medical records contain both confidential information and shareable information and the EHR system cannot separate these two types of information, the clinician withholding certain data to protect privacy does not constitute information blocking.
- 2. Privacy Exception:** This exception is invoked when the information withheld is legally protected by state or federal law or if the patient specifically requests that their information not be disclosed. State minor consent and privacy laws and HIPAA regulations may help support this exception for adolescents.
- 3. Preventing Harm Exception:** This exception applies when withholding information is necessary to prevent substantial harm, including psychological, physical, or emotional harm.

These exceptions attempt to balance the need for transparency and access to health information with EHR system limitations and the imperative to protect patient privacy and well-being, especially in sensitive cases involving minors. Effective implementation requires customizable and automated granular segmentation to separate EHI so discrete information can be shared differently through portal systems to adolescent patients, proxies, and HIEs. It is crucial for clinicians to understand system capabilities and how their respective EHR systems are implementing the Cures Act to better navigate the complexities of healthcare technology and promote access to confidential care for adolescents.

Information Sharing and Information Blocking Under the ONC Rule: Key Questions to Consider Regarding Adolescent Confidentiality

To determine if sharing an adolescent’s information is required under the ONC rule, the following questions may provide guidance and clarity:
Is the information EHI subject to sharing under ONC Rule?
Is the information sensitive?
Does the patient have concerns about disclosure and, if so, to whom?
Does the clinician have concerns about disclosure and, if so, to whom?
Who would have access to the information?
Is there a basis for not disclosing the information under one of the 8 exceptions to information blocking under the ONC Rule?
Does the infeasibility exception apply (e.g., segmentation is not possible)?
Does the privacy exception apply (e.g., disclosure prohibited by federal or state law or nondisclosure respects patient’s wishes)?
Does the preventing harm exception apply (e.g., does the provider reasonably believe that disclosure would cause harm that meets the standard in the ONC Rule)?
Does any of the other exceptions to information blocking apply?
If not disclosing the information would be permissible under the ONC Rule, is there an automated mechanism in the electronic health record for protecting the information?
If there is no automated mechanism, is there a manual mechanism for a clinician to protect the information from disclosure?
If there is no automated or manual mechanism for protecting the information, what is the best avenue within the health site or system to advocate for the development of a mechanism?

Key questions to consider regarding information blocking, information sharing, and adolescent confidentiality under the ONC rule.²⁴

Recommendations for EHR Standards

For additional information on EHR standards please visit the following websites:

ncbi.nlm.nih.gov

jahonline.org

The American Academy of Pediatrics (AAP) and the Society for Adolescent Health and Medicine (SAHM) have provided recommendations to protect confidential care for adolescents. Some recommendations for EHR standards and functionalities include:

1. Functionality to designate as confidential entire visit notes, or portions of visit notes when a single patient encounter may generate both sensitive and nonsensitive data.^{25, 26}

The challenge of managing sensitive and confidential information within EHR systems can be significant, particularly when it involves both sensitive and non-sensitive data within the same document. Many EHR systems lack the functionality to selectively block or hide specific portions of visit notes. However, creating distinct confidential note types and encouraging the practice of separating sensitive information into distinct notes are effective strategies for managing sensitive data within EHRs.

At Arnold Palmer Medical Center in Orlando, Florida, clinicians developed a confidential “Adolescent Sexual and Reproductive Health” note type. The note type is used to document visits where adolescents access confidential sexual and reproductive health services unaccompanied by their parents. The note type is also used to separately document sexual and reproductive health services that are delivered when adolescents present with 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 type. Both note types are not released to the patient portal to which the parent may have full access and are not released to parents without minor consent when hard copies of the medical record are requested.

2. Functionality to designate problems, medications, laboratory and radiology 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.²⁵

Hennepin County Medical Center in Minneapolis, Minnesota, 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 or discharge summaries and from the patient portal to which the parent may have full access.

The Children’s Hospital of Colorado 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 the “Secure AVS” prior to printing to ensure sensitive information has been filtered.

3. Functionality to provide differential access to information (e.g., via patient portals) for parents and adolescents.²⁵

While differential access to information can be applied according to clinical role (e.g., clinicians 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 to 17 years.²⁷

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 of access to clinical information, which may include information related to sensitive services such as STI and contraceptive care. Additionally, clinicians are encouraged to discuss with adolescents the steps they can take, if any, to terminate parent portal access at the point of care and the potential ramifications of their parent discovering that their portal access status has been terminated at the request of the adolescent.

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.²⁹ Clinicians caring for adolescents must educate vendors and purchasing institutions about existing adolescent confidentiality laws and the desirability of robust privacy settings.²⁵ Health care providers can also help develop patient portal policies in their respective practice settings to promote and protect confidential health care for adolescents.

While the terms **Electronic Medical Record (EMR)** and **Electronic Health Record (EHR)** are often used interchangeably, they represent distinct concepts. In essence, all EHRs are EMRs, but not all EMRs qualify as EHRs. Both systems involve the digital documentation of patient health information; however, the principal distinction lies in **interoperability**—the capacity to exchange health data across different healthcare entities.

An **EMR** is generally confined to a single practice or organization and is not readily designed to share information beyond that setting. In contrast, an **EHR** is developed to facilitate the secure transfer and integration of patient information across multiple practices, health systems, and care settings. This interoperability allows a patient's health record to accompany them throughout the continuum of care, thereby promoting better coordination, continuity, and quality of healthcare delivery. The tables below highlight institutional process considerations for EMR implementation, use, and optimization in adolescent medicine.

Considerations for implementing and optimizing current EMRs for adolescent medicine

Institutional process considerations for EMR use in adolescent medicine

PATIENT EXPERIENCE	INSTITUTIONAL PROCESS CONSIDERATIONS
1) Appointment scheduling, clinic or hospital registration/check-in	Train scheduling, registration, and support staff in: ➤ Adolescent confidentiality laws and policies ➤ Exercising caution in discussing reason(s) for visit in presence of parents or in public
2) Clinic visit/hospital intake	Train clinical staff in: ➤ Medication reconciliation procedures both with and without parents present ➤ Marking confidential information appropriately in the EMR, where technically possible ➤ Recognizing how confidential information is tagged with the EMR Train all support staff in: ➤ Not discussing any EMR entries flagged as confidential in the presence of parents
3) Follow-up, billing, & financial	Train clinical support staff in: ➤ Not discussing in the presence of parents those patient medications and lab results flagged as sensitive Train coding, billing, and financial staff in: ➤ Confidential services and personal health information that should not be discussed with parents ➤ Acceptable coding and billing procedures for specific confidential services for adolescents Train scheduling, quality improvement, marketing, and patient experience staff in: ➤ Not sending appointment reminders and follow-up surveys (mail or phone) to parents for adolescent confidential visits
4) Release of information/health information exchange	Train medical records and health information staff in: ➤ Confidentiality rights of adolescent patients ➤ Release of information best practices and policies related to adolescent patient visits

Institutional process considerations for EMR use in adolescent medicine.²⁹



- Multistakeholder task force committed to addressing adolescent confidentiality issues within health care system
- Clear labeling of sensitive information
- Automatic nonrelease of specific sensitive elements of adolescent patients' electronic records
- Linkage of all adolescent patient prescriptions/ medication orders with specific diagnosis or problem
- No billing, after-visit summaries, explanation of benefit, appointment reminders, or follow-up surveys posted to portals or mail for adolescent sensitive services
- Limited patient portal access for adolescents until more robust EMR privacy functionality

Considerations for implementing and optimizing current EMRs for adolescent medicine.²⁹

Medical Information Release

Medical information releases for adolescent patients are best reviewed by a member of the health care team to prevent the inadvertent release of confidential information. Generally, parents or guardians are responsible for authorizing the release of a minor's medical information. However, in certain situations, the adolescent's authorization may be required for the release of information.

Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Privacy Rule, established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, provides individuals with the right to access and obtain copies of their health information and medical records, referred to as protected health information (PHI).³⁰ HIPAA also specifies when an individual's authorization is required for disclosure of PHI. The rule balances the need to protect minors' health information with parental access rights and provides important safeguards for adolescent confidentiality while respecting other state and federal laws and allowing healthcare providers to use their professional judgment.³¹

Under the HIPAA Privacy Rule, adolescents over 18 years of age and emancipated minors can exercise the rights of individuals. For adolescents under 18 years of age, parents (including guardians and persons acting in loco parentis) are the "personal representatives" of their unemancipated minor children if they have the right to make health care decisions for them. As personal representatives, parents generally have access to their children's PHI.

In specific circumstances, however, parents may not be the personal representatives of their minor children. A minor is considered "the individual" who can exercise rights under the rule in one of three circumstances.³¹

- When the minor has the right to consent to health care and has consented, such as when a minor has consented to treatment of an STI under a state minor consent law.
- When the minor may legally receive the care without parental consent, and the minor or another individual or a court has consented to the care, such as when a minor has requested and received court approval to have an abortion without parental consent or notification.
- When a parent has assented to an agreement of confidentiality between the health care provider and the minor, which occurs most often when an adolescent is seen by a clinician who knows the family.

In each of the above circumstances, the parent is not the personal representative of the minor and does not automatically have the right of access to health information specific to the situation unless the minor requests that the parent act as the personal representative and have access. Under these circumstances, who may have access to the adolescent's health records depends on "state or other applicable law".^{14, 31}

Arizona's statutes on the confidentiality and release of medical records do not address the confidentiality of a minor's medical record.³² However, Arizona's Parents' Bill of Rights gives parents:

- The right to request, access, and review all written and electronic medical records of the minor child unless otherwise prohibited by law or unless the parent is the subject of an investigation of a crime committed against the minor child and a law enforcement official requests that the information not be released. A.R.S. § I-602(A)(6).⁵⁸

There is some tension between the HIPAA privacy rule and the Arizona Parent's Bill of Rights regarding parent access to their child's health care records. This apparent conflict may embolden parents to challenge the withholding of HIPAA protected records for care that the minor alone can consent to and ultimately may require legal clarification or judicial review.

Clinicians are encouraged to establish their practice policies and collaborate with their healthcare institution's legal counsel, risk management, and compliance teams, where applicable, when questions arise regarding confidentiality, parental access to records, and documentation practices. Open communication with adolescents and their families about the purpose, benefits, and limits of confidential care can help preserve trust, promote adolescent health and safety, and support compliance with applicable laws, regulations, institutional policies, and professional standards.

Importantly, the HIPAA Privacy Rule also allows minors who are treated as "individuals" to request special privacy protections from their clinicians and insurance plans. These provisions are particularly important when the minor believes disclosure of information would subject them to harm.³⁴ First, the minor may request that the use and disclosure of their PHI be limited to what is necessary to carry out treatment, payment, or health care operations.³⁵ Second, minors may request that their clinicians and health insurers communicate with them in a confidential manner, such as via closed envelope rather than postcard, by email rather than phone, or at a place other than their residence.³⁵ Clinicians must accommodate reasonable requests for confidential communication, but health plans need only accommodate requests if the individual clearly states that the disclosure could endanger the individual.^{35, 36} HIPAA, however, does not define "endanger."

Unlike Arizona, several states have enacted laws to give minors stronger privacy protections than HIPAA. For example, the California Confidentiality of Medical Information Act requires insurers to honor confidential communication requests for information relating to sensitive services, such as birth control, STI tests, or mental health care, without any showing of endangerment.³⁷ California's law is intended to help ensure that confidentiality concerns do not deter young adults from obtaining health care coverage and services.

The HIPAA Privacy Rule provides for the withholding or disclosure of a minor's protected PHI for health and safety reasons. It allows a licensed health care professional to

deny a parent who is a personal representative access to a minor's protected health information if, in the professional's judgment, access would likely cause substantial harm to the minor or someone else.^{34, 38} It also allows clinicians or health plans to disclose a minor's protected health information in order to prevent or diminish an imminent threat to the health and safety of a person or the public.^{34, 39}

Arizona's Parents' Bill of Rights

In 2010, Arizona enacted the Parents' Bill of Rights, recognizing a fundamental right of parents to direct the healthcare and mental health of their minor children. ARS I-601(A).⁷¹ Specifically, the Parents' Bill of Rights states that "all parent rights are exclusively reserved to a parent of a minor child without obstruction or interference from this state, any political subdivision of this state, any other governmental entity or any other institution, including:

- The right to make all health care decisions for the minor child, including rights pursuant to sections I5-873, 36-2271 and 36-2272, unless otherwise prohibited by law. A.R.S. § I-602(A)(5).⁵⁸
- The right to request, access and review all written and electronic medical records of the minor child, unless otherwise prohibited by law or unless the parent is the subject of an investigation of a crime committed against the minor child and a law enforcement official requests that the information not be released. A.R.S. § I-602(A)(6).⁵⁸

The law further provides that government entities cannot infringe on that right without demonstrating a compelling, narrowly-tailored interest, and that a parent may bring suit against a governmental entity or official who violates the Parents' Bill of Rights. ARS I-601(B); ARS I-602 (B) and (E)-(G).^{58, 71}

Importantly, the Parents' Bill of Rights references both public and private entities but only grants parents the right to sue for violations by governmental entities or officials. However, the broad language of the statute can create uncertainty and concern for healthcare providers and institutions, particularly when balancing parental rights with existing laws that allow minors limited rights to confidential healthcare services. As mentioned above, there appears to be some tension between the Parents' Bill of Rights and HIPAA's privacy protections for minor records, and this may invite a challenge to the withholding of HIPAA protected records in some circumstances.

Clinicians often strive to balance respect for parental rights and family involvement, the developmental importance of helping adolescents build independence and healthcare self-management skills, and legal protections for confidential adolescent care in specific circumstances. Clinicians are encouraged to establish their practice policies and collaborate with their healthcare institution's legal counsel,

risk management, and compliance teams, where applicable, when questions arise regarding confidentiality, parental access to records, and documentation practices. Open communication with families about the purpose and limits of confidential care can help maintain trust while supporting adolescent health, safety, and appropriate legal and regulatory compliance.

Code of Federal Regulations (CFR)⁴⁰

The Code of Federal Regulations (CFR) are a codification of general and permanent rules published by the federal government.⁴² CFR Part 2 and Part 8 are federal regulations that protect patient confidentiality and ensure the safety of patients in Substance Use Disorder (SUD) treatment programs.

42 CFR Part 2 limits when and how information about SUD treatment can be shared to address concerns that discrimination and fear of prosecution may deter individuals from entering treatment. The regulations protect the confidentiality of patient records for SUD treatment, education, prevention, and research. They also require treatment clinicians to follow privacy and confidentiality restrictions, including protections for SUD counseling notes maintained separately from the rest of a patient's medical record. Finally, the regulations include strict requirements for patient consent to the disclosure of records. SUD treatment records cannot be used to investigate or prosecute the patient without written patient consent or a court order.

42 CFR Part 8 provides a framework for treating opioid use disorder using opioid agonist medications, specifically buprenorphine and methadone at the time of this writing. The regulations govern the accreditation, certification, and treatment standards of opioid treatment programs (OTPs). 42 CFR Part 8, § 8.12 (C) specifically states that, except in states where state law grants persons under 18 years of age the ability to consent to OTP treatment without the consent of another, no person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.

Health Insurance Plans⁴¹

Health insurance plans can impact adolescents' access to confidential health care. One of the most critical challenges is the potential for breaches of confidentiality in the Explanation of Benefits (EOB) process.

Although Arizona Medicaid plans do not do so, commercial health plans routinely send EOB statements to policyholders after anyone covered under their policy obtains care. An EOB typically identifies the individual who received care, the clinician, and the type of care obtained. It also includes information on the amount charged for the care, the amount reimbursed by the insurer, and any remaining financial

obligation on the part of the policyholder or patient.

These statements can inadvertently reveal sensitive health information, undermining the confidentiality that is essential for effective adolescent care.

This raises important questions:

Do health insurance plans have policies on confidential health care for adolescents?

Can the clinician or covered dependent request that the health insurance plan withhold an EOB statement to protect confidentiality?

Can clinicians bill adolescents directly and not access their plan benefits as covered dependents?

In Arizona, health insurance plans generally lack policies on confidential health care for minors and have no specific protections or procedures for its delivery. To the knowledge of this guide's authors, none of the plans currently allow for the suppression of individual EOBs that would enhance clinicians' ability to offer confidential care to adolescents.

Historically, some clinicians have circumvented the challenges associated with the EOB process by billing adolescents directly or referring them to Title X family planning clinics. However, certain health insurance plans may prohibit direct billing of patients for covered services. Moreover, adolescents might face various obstacles when attempting to follow through on a referral to a Title X family planning clinic.

To protect confidential healthcare for adolescents, particularly concerning the EOB process, health insurance plans should consider implementing the following recommendations:

1. Develop Clear Policies on Confidential Adolescent Care:

- Establish Confidentiality Guidelines: Create specific policies that protect the confidentiality of adolescent health care services, especially for sensitive services like reproductive health and substance use treatment. These policies must align with relevant state and federal laws regarding minor consent and confidentiality in healthcare.

2. Modify Explanation of Benefits (EOB) Procedures:

- EOB Suppression for Sensitive Services: Implement an option to suppress or withhold EOBs for services deemed sensitive when an adolescent is the primary recipient. This could include services like sexual and reproductive health.
- Send EOBs Directly to Adolescents: If EOBs cannot be entirely suppressed, send them directly to the adolescent (if legally permitted) rather than to the policyholder, typically a parent or guardian.
-



- Confidential Communication Requests: Implement effective processes that allow adolescents or their clinicians to request that communication regarding specific services be sent to an alternative address or through secure, private electronic communication channels.

3. Train Staff on Adolescent Confidentiality:

- Training Programs: Provide ongoing training for customer service representatives, billing staff, and clinicians on the importance of adolescent confidentiality and the specific policies in place to protect it.
- Handling Confidentiality Requests: Ensure that staff are trained on how to handle requests for confidentiality sensitively and effectively.

Federally-funded Title X Clinics

The federal Title X family planning program, established in 1970, provides family planning and related health services either for free or at a low cost to eligible individuals, including adolescents, in every state.⁴² The program is a vital part of the U.S. public health safety net, aimed at serving individuals with lower incomes and those without insurance who might otherwise struggle to afford family planning services. Individuals with an income below 100% of the federal poverty level are eligible to receive services at no cost. Key services provided under Title X include cervical and breast cancer screenings, contraceptive care, preconception care, and testing and treatment for sexually transmitted infections, including HIV. Title X programs are prohibited from offering abortion as a method of family planning.

Title X statutes and regulations are designed to reduce barriers to healthcare and protect the privacy of adolescent patients by establishing consent and confidentiality requirements. Clinicians must adhere to these rules and regulations when offering Title X services. Importantly, Title X-funded services must be made available to all adolescents regardless of age, and courts have determined that minors of any age may consent to services funded by

Title X without requiring parental consent or notification. Title X regulations also mandate that clinicians keep all patient information confidential, with disclosure allowed only if the patient provides written authorization, the release is necessary for service provision, or state or federal law requires it. Clinicians are also required to implement appropriate safeguards to maintain confidentiality.

Federal appropriations bills funding the Title X program explicitly state that Title X-funded agencies are not exempt from state mandatory child abuse reporting laws. Additionally, Title X allows for the reporting of certain communicable diseases to local public health departments or authorities when mandated by state law. While Title X regulations encourage youth to involve a trusted adult in their healthcare decisions, their involvement is not required to receive services.

Affirm (formerly Arizona Family Health Partnership) is a nonprofit organization that has been the Title X grant recipient in Arizona since 1983. Affirm, in turn, distributes funds to health centers that provide sexual and reproductive healthcare and other preventative services. Title X-funded clinics are a valuable resource for adolescents seeking confidential sexual and reproductive health services. A listing of Title X clinics in Arizona can be found at sexfyi.org.

Tribal Territories

The applicability of state and federal adolescent confidentiality statutes on tribal land can be complex and depends on several factors, including the specific statutes in question and the nature of tribal sovereignty.

Federal laws, including those related to adolescent confidentiality in healthcare, such as HIPAA and the federal guidelines on confidential care for minors, apply across the United States. State laws on adolescent confidentiality also generally apply within the state's jurisdiction. However, tribal nations have a high degree of sovereignty, and tribal land is often considered outside the direct purview of state laws. Tribes have the authority to establish their own legal systems and may have specific laws or regulations regarding the confidentiality of adolescent health information. These tribal laws can be different from state or federal statutes.

In practice, whether state and federal laws apply directly on tribal land can depend on agreements between tribal authorities and external entities, including state and federal governments. The authors of this guide are not aware of any tribal jurisdictions in Arizona that have laws on confidentiality that differ from existing federal and state laws. For clinicians or other entities working within tribal jurisdictions, it is crucial to stay current on tribal regulations and consult with tribal authorities where appropriate to ensure compliance with local laws and respect for tribal sovereignty.



The Law

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

Regulations relating to health care for minors come from diverse sources and include Title X Family Planning regulations, which are issued by both the federal Department of Health and Human Services (HHS) and state health agencies; confidentiality regulations for drug and alcohol treatment programs issued by HHS, and regulations concerning contagious diseases, STIs, and human immunodeficiency virus (HIV) issued by state health departments, among others.

For the purposes of consent to care, a minor is a person

under 18 years of age. In general, a minor may receive treatment only if a parent or guardian provides consent or the treatment involves emergency medical care and the parent is unavailable for consent. There are exceptions to this rule that allow minors to self-consent based on *the status of the minor or the specific service the minor seeks*, discussed below. 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. Given that minors may lack the full capacity to understand complex medical information, it is important to ensure that the minor comprehends the nature of the treatment, its risks, and benefits. Additionally, time must be taken to explain the information in a way that is understandable to the minor, considering their developmental stage.

Status Exceptions

Status exceptions may exist if the minor is emancipated, married, or homeless (A.R.S. § 44-132); a veteran entitled to G.I. benefits, or that veteran's spouse (A.R.S. § 44-131); or active-duty military.^{43, 44}

Emancipated Minors

An emancipated minor is commonly viewed as an individual who lives away from the parent, is free from parental control, and is self-supporting. To be emancipated in Arizona, a minor must be at least sixteen years old, a resident of Arizona, financially self-sufficient, and file a petition with and attend a court hearing to demonstrate self-sufficiency. (A.R.S. § 12- 245I).⁴⁵ Attending school out of state would not, for example, indicate emancipation if the parent/guardian remains the child's source of support. If an emancipation order is issued by the court, the minor is neither under a legal duty of service to their parent nor entitled to their parent's support under Arizona law.

Married Minors

Married adolescents are automatically treated as emancipated minors and have the legal authority to make their own decisions about their medical care, including consenting to the release of their medical information. They do not have to go through the court process detailed above. There is no similar automatic emancipation for an

unmarried pregnant minor or an unmarried minor parent (A.R.S. § 44-132).⁴³

Homeless Minors

A homeless minor can consent to medical care (A.R.S. § 44-132).⁴³ Homelessness can be difficult to document, and there are differing definitions of homelessness. For purposes of consent, Arizona statute defines a homeless minor as an individual under the age of 18 years living apart from their parents and who lacks a fixed and regular nighttime residence or whose primary residence is either a supervised shelter designed to provide temporary accommodations, a halfway house, or a place not designed for or ordinarily used for sleeping by humans (A.R.S. 44-132(C)).^{43, 46}

Minors in the Military

According to case law, minors who have enlisted in the military are considered emancipated and able to make their own health care decisions. Arizona statute also provides that a veteran who is entitled to benefits under the Servicemen's Readjustment Act of 1944 (P.L. 78-346; 58 Stat. 284), or the spouse of that veteran, have the authority to contract as adults even if the veteran or spouse is a minor (A.R.S. § 44-131).^{44, 47} Thus, a minor who is active-duty military or a qualifying veteran and their spouse can generally consent to medical care.

Service Exceptions

Family Planning Services/Contraceptive Care

Since 1970, the federal Title X Family Planning Program has assured confidential access to reproductive health or family planning services for adolescents. Title X regulations require that services must be made available confidentially to adolescents regardless of age. The Title X Program encourages family involvement, but parental notification or consent is not required.

Outside of the Title X program setting, no Arizona statute specifically addresses minor consent to family planning services. However, an opinion issued by the State Attorney General in 1977 states that a minor may consent to contraceptive care.⁴⁸ The opinion also states that an agency or clinician who delivers such services will not be civilly or criminally liable to the parents or guardian of a minor who requested the care. It is advisable to document the rationale for treatment and the minor's informed decision-making capacity when providing family planning services without parental consent.



Pregnancy Related Care

There are no specific Arizona statutes addressing the right of minor parents or pregnant minors to consent to their own care. Nor is there any Arizona statute recognizing the “mature minor doctrine”, which allows minors to consent to care if they are deemed sufficiently mature.⁴⁹ Despite the absence of Arizona statutory authority, in practice, clinicians generally recognize the pregnant minor's ability to consent to their own pregnancy-related care. This includes prenatal, delivery, and post-natal services and treatment for complications. Given the absence of explicit legal authority, clinicians should clearly record the reasons for proceeding without parental consent, emphasizing the necessity and benefits of the care provided and that proceeding without parental consent was warranted to help mitigate the risk of liability.

Sexually Transmitted Infections (STIs)

For care relating to sexually transmitted diseases, a minor may consent to diagnosis and treatment of STIs. Parent or guardian consent is not necessary to authorize hospital or medical care (A.R.S. § 44-132.01).⁴³

HIV Testing, Treatment, and Prevention

There is no statute in Arizona specifically addressing minor consent to human immunodeficiency virus (HIV) testing, treatment, and prevention (including PrEP and PEP). However, A.R.S § 44-132.01, which allows minors to consent to diagnosis and treatment of sexually transmitted infections (STIs), could be interpreted to permit HIV testing and treatment without parental consent.⁴³ Additionally, biomedical prevention (PrEP and PEP) might be interpreted as being included under a broad definition of treatment or services.

While minors are generally able to consent to HIV testing, practices vary across Arizona regarding offering HIV treatment and biomedical prevention services to minors without the need for parental consent. Clinicians are advised to consult with relevant stakeholders in their respective settings to define policies and practices for HIV-related care based on their interpretation of STI statutes and legal guidelines. If providing HIV-related services confidentially to minors, special attention must be given to how these visits are documented in the medical record and the additional steps that may be needed to limit access to this information and prevent breaches of confidentiality.

Sexual Assault

The care relates to rape or sexual assault, and the minor is 12 years of age or older (A.R.S. § 13-1413).⁵⁰

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. Parent or guardian consent is not necessary to authorize hospital, medical and surgical examination, diagnosis, and care. Clinicians must report all sexual assaults to either law enforcement or the Arizona Department of Child Safety.

Adoption

Minor parents may provide consent to adoption in Arizona (A.R.S § 8-106).⁵⁷ The minority of the child or parent does not affect the child's or parent's competency to give consent in the instances set forth in this section.

Substance Use

Minors in some circumstances may consent to substance use–related evaluation and treatment, particularly in emergencies involving intoxication or withdrawal. However, parental consent is generally still required for ongoing mental health or behavioral health treatment unless another statutory exception applies.

The care relates to alcohol or alcohol use disorder (A.R.S. § 36-2024):⁵¹

An alcoholic may apply for evaluation and treatment directly to any approved public or private treatment facility. If the applicant is a minor or incompetent person, either the applicant or a parent, legal guardian, or other legal representative of the applicant shall apply for evaluation and treatment.

The care relates to emergency care for substance use, and the minor is 12 years of age or older (A.R.S. § 44-133.01):⁵²

Notwithstanding any other law, any minor who is at least twelve years of age who is found, upon diagnosis of a licensed physician or a registered nurse practitioner, to be under the influence of a dangerous drug or narcotic, which includes withdrawal symptoms, may be considered an emergency case and the minor is considered as having consented to hospital or medical care needed for treatment for that condition. Such consent is not subject to disaffirmance because of minority. The consent of the parent, parents or legal guardian of that minor is not necessary to authorize hospital or medical care, except that the consent is equally valid if obtained.

There is no statute in Arizona specifically addressing minor consent to substance use disorder treatment where the minor is not acutely under the influence of a dangerous drug or narcotic that may be considered an emergency case. As such, parent consent is generally required for all other non-emergency substance use-related treatment. Additionally, 42 CFR Part 8, which provides regulations governing the accreditation, certification, and treatment standards of opioid treatment programs (OTPs), specifically states that, absent a state law to the contrary, minors cannot be admitted to OTPs without the written consent from a parent, legal guardian, or responsible adult designated by the relevant state authority (42 CFR Part 8, § 8.12 (C)).⁵³ Clinicians are advised to consult with relevant stakeholders in their respective settings to define policies and practices for minor consent to non-emergency substance use disorder treatment based on their interpretation of statutes and legal guidelines.

No Arizona statute states that a minor must be informed of and agree to drug testing requested by a parent or guardian. However, parents requesting drug testing should be informed that drug testing without the adolescent's knowledge could undermine trust in both parents and the

clinician. Parents should also be informed of the limitations of drug testing. Standard drug tests often screen for only a limited range of substances and may not detect all drugs or identify new or synthetic substances. Drug testing also only assesses substance use at a specific point in time and does not give insight into patterns or the context of use. A negative test result does not necessarily rule out a substance use disorder. Additionally, drug tests alone do not provide information on the reasons behind substance use or the psychological and social factors involved, which are crucial for effective intervention and treatment.

However, this may be an instance where the clinician can foster communication and positively impact the parent-adolescent relationship. Parents requesting such tests should be queried about their underlying concerns and motivations. By exploring these, clinicians can help parents understand the potential implications of their requests and encourage a more collaborative and supportive approach to addressing their adolescent's needs.

Emergencies

In general, no one may procure or perform surgical procedures on a minor without first obtaining specific written consent of the parent or legal guardian except in the case of an emergency when such procedure is necessary for the treatment of 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. § 36-227I).⁵⁴

Notwithstanding any other provision of the law, in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and after reasonable efforts made under the circumstances, the parents of such minor cannot be located for the purpose of consenting thereto, consent for said emergency attention may be given by any person standing in loco parentis to said minor(A.R.S 44-133).⁵²

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. Clinicians must use their best clinical judgment to assess whether a situation qualifies as an emergency. The focus should be on the urgency of the medical need rather than a strict definition of "life-threatening." It is crucial for clinicians to document their efforts to contact the minor's parent or guardian, including the time and method of contact attempts, any responses received, and the rationale for proceeding with treatment without consent.



Additional Services & Special Considerations

Mental Health Screening and Treatment

Arizona law also forbids anyone from procuring or performing a mental health screening in a nonclinical setting or performing 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 screening or treatment to prevent serious injury to or save the life of a minor child (A.R.S. § 36-2272).⁵⁵

If the visit with the adolescent raises concern for a mental health disorder, an assessment of whether referral for further evaluation and treatment is necessary is recommended.

Emergency Contraception

Parental consent is not required for minors to access emergency contraception (levonorgestrel, ulipristal acetate). While ulipristal acetate requires a prescription, levonorgestrel containing emergency contraception was approved by the U.S. Food and Drug Administration (FDA) for over-the-counter, non-prescription use without age restrictions on June 20, 2013.

Abortion

Under Arizona law, a physician 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. Parental consent is not required if the pregnancy resulted from sexual contact with the minor's parent, stepparent, uncle, grandparent, sibling, adoptive parent, legal guardian, foster parent, or an unrelated male living with the adolescent and their mother. Additionally, no parental consent is needed if the attending physician, based on 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 irreversible impairment of major bodily function (A.R.S. § 36-2152).⁵⁶

Parenting Adolescents

Unlike many other states, Arizona does not have a law specifically addressing a minor parent's right to consent to medical care for their child. However, Arizona's parents' bill of rights states that a parent of a minor child has the right to make "all health care decisions for the minor child," and the statute does not make any distinction based on the parent's age A.R.S. I-602(A)(5)).⁵⁸ Thus, a parenting adolescent may have the right to consent to their child's medical care but not their own medical care, unless they are emancipated or meet one of the other criteria for self-consent.

Immunizations

In Arizona, adolescents cannot consent to any immunization unless they are emancipated or there is a court order. This includes immunizations against Human Papillomavirus (HPV) and Hepatitis B Virus (HBV), which are primarily or potentially transmitted through sexual contact, respectively. A handful of other states have passed a variety of laws allowing adolescents to consent to immunizations.⁵⁹ While some state laws allow adolescents to consent specifically to immunizations for either or both HPV or HBV, others allow adolescents to consent to all immunizations if they are mature minors or above a certain age.

Mature Minors

The "mature minor doctrine" is based on the concept that certain adolescents, despite not being legal adults, may possess the maturity and understanding necessary to make informed decisions about their own medical care. 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."⁶⁰ Under this doctrine, mature minors can consent to their own care if they can give informed consent, particularly in sensitive areas such as reproductive health.

There is no standardized legal definition of a "mature minor," and its application can vary widely. Jurisdictions recognizing the "mature minor doctrine" have found the minor mature if they are 15 years of age or older; they understand the benefits and risks of the proposed care; the care is beneficial and necessary; and there is a good reason (including the minor's objection) to proceed without parental consent. While several states have codified the mature minor doctrine in their statutes, Arizona statutes do not recognize this doctrine. The authors of this guide are also not aware of any cases specifically testing the use of the mature minor doctrine in Arizona.



Minors in Custody of Juvenile Court or the Department of Child Safety (DCS)

Minors in the custody of the juvenile court cannot be hospitalized for evaluation or treatment, unless in an emergency, without approval by the court upon application filed by the child's probation officer, parole officer, case worker, or attorney. When a child under the jurisdiction of the juvenile court appears to be in need of medical or surgical care, the juvenile court may order the parent, guardian or custodian to provide treatment for the child in a hospital or otherwise. If the parent, guardian or custodian fails to provide the care as ordered, the juvenile court may enter an order therefore, and the expense, when approved by the juvenile court, shall be a county charge. The court may not order a child or the parent or guardian of a child who is in residential placement as a term of probation, detention or incarceration to pay for treatment expenses. (ARS 8-245).⁶¹

For children in the custody of DCS, if parental rights have not been severed, DCS shall, to the greatest extent possible, consult with the child's biological parents when making health care decisions for a child.

If DCS has temporary custody of a child or has legal custody pursuant to a court order, the department may consent to the following:

- Evaluation and treatment for emergency conditions that are not life-threatening;
- Routine medical and dental treatment and procedures, including early periodic screening diagnosis and treatment services, and services by health care clinicians to relieve pain and treat symptoms of common childhood illnesses or conditions;
- Surgery
- Blood transfusions
- General anesthesia
- Testing for the presence of HIV

For surgery, general anesthesia, or blood transfusion, DCS shall, if possible, obtain consent from the parent or guardian. For children placed under a "Voluntary Placement Agreement," unless there is an emergency, the department shall obtain the consent of the parent or guardian for surgery, general anesthesia, or blood transfusion. If there is an emergency and the child needs immediate hospitalization, medical attention, or surgery, a DCS specialist or out-of-home caregiver may consent to treatment.

The department may not consent to abortions; see [Pregnancy Care Services and Abortion](#).

The department shall confirm that prior to a child participating in a clinical trial, all required consents are obtained, and an independent advocate is appointed for the child.

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 does not have the right to consent to care for the minor, except in emergency situations and if the biological parent expressly grants that authority. 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.

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 of a minor patient is legally sufficient for treatment. However, where parents are divorced or legally separated, it is important to identify which parent(s) holds legal custody to identify whose consent is required for treatment. This is especially true if divorced or legally separated parents disagree about the performance of a particular treatment. Consulting with legal counsel is recommended when dealing with complicated custody arrangements or conflicts between parents.

Treatment when Parents Disagree

Generally, the clinician is not obligated to seek the consent of both parents. However, if it becomes apparent that there is a disagreement between custodial parents, it is wise to encourage them to resolve their disagreement and not proceed with treatment in the absence of an emergency or without a court order authorizing treatment. Upon application, a court may order the 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

Persons with temporary care of a minor generally may not consent to medical treatment for the child. However, parents or guardians can delegate their right to consent to medical treatment to someone temporarily caring for a minor. This is often done through a written form, such as a “continuing consent to treatment of minor” document. In cases where the minor is seriously ill or requires significant treatment, every effort should be made to contact the parent or guardian, even if consent has been delegated.

Adolescents and Young Adults with Intellectual or Developmental Disorders

Adolescents and young adults with intellectual or developmental disorders (I/DD), including autism spectrum disorder and cognitive or intellectual delays, may present unique legal and ethical challenges regarding consent and confidentiality. Assessing an adolescent or young adult’s cognitive abilities, socioemotional development, and level of independence is crucial for making informed decisions about providing confidential care. Involving a parent or guardian, particularly when they have legal guardianship, can often be beneficial. However, it is important to recognize that there may be information the adolescent or young adult might wish to discuss in private and not share with their parent or guardian. Prioritizing confidentiality in interactions with individuals with I/DD supports their dignity, independence, and overall well-being and fosters meaningful, respectful relationships built on trust and mutual understanding.

The sexual development of children and adolescents with I/DD is often an overlooked topic. Their complex medical and functional needs often take precedence, which can limit the time spent addressing the anatomical, physiological, emotional, and social aspects of their sexuality. Many youths with I/DD engage in and seek consensual sexual relationships and need guidance from clinicians on topics such as sexually transmitted infections (STIs) and pregnancy prevention. Individuals with I/DD experience sexual violence at significantly greater rates than their peers, making discussions regarding consent, boundaries, and protection from abuse/assault important. Balancing confidentiality with the need to ensure their safety and provide appropriate support is vital.

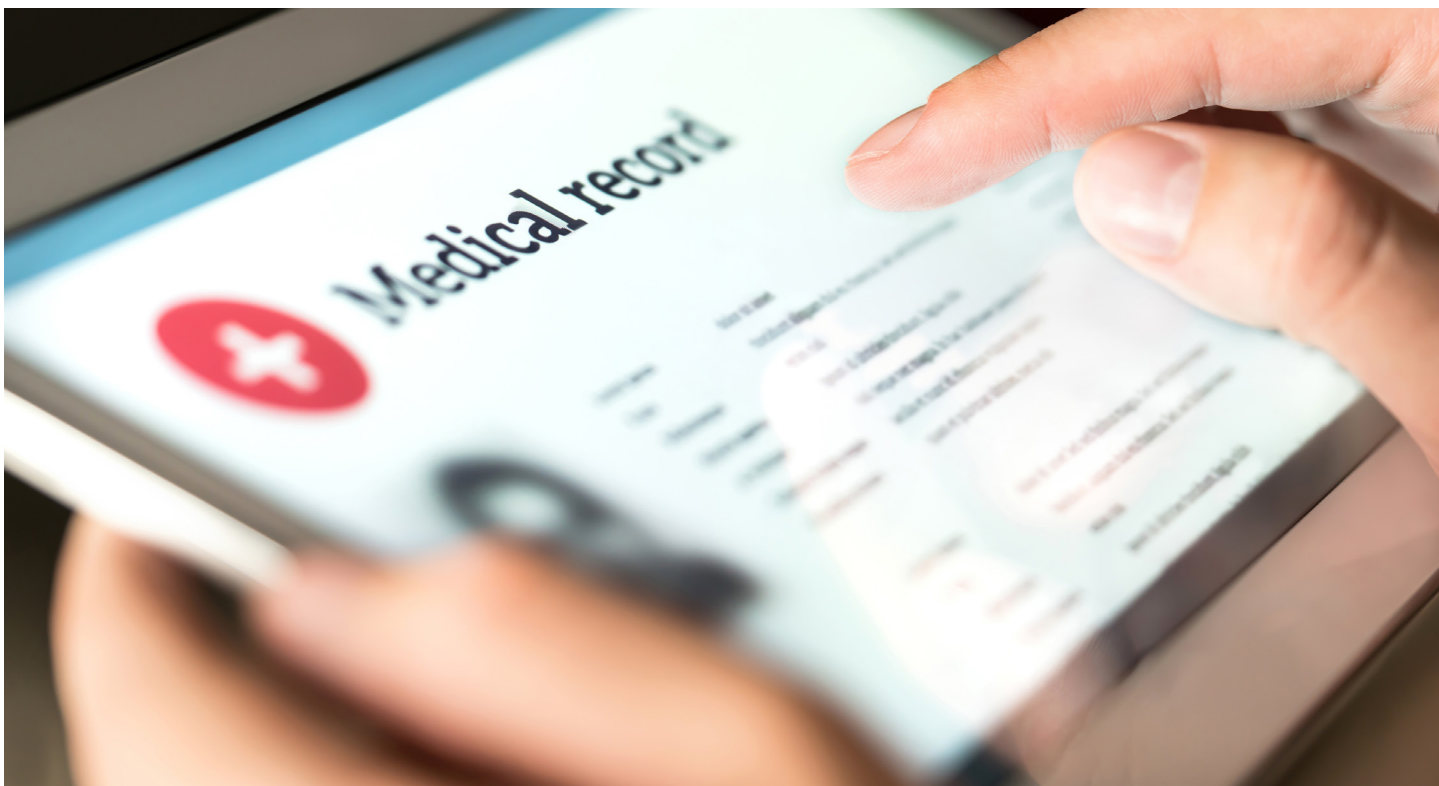
Refusal of Consent by the Minor

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 the minor’s parents or legal guardians consent to the minor’s care, the clinician should normally comply with parental instructions that are consistent with the patient’s best interest.

Medical Records Release

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 clinician’s rights and duties regarding the confidentiality of a minor’s medical records.

A clinician may only disclose this information pursuant to law or the written authorization of the patient or the 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.⁶² 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 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 Reporting

Clinicians are required to report communicable diseases to the Arizona Department of Health Services regardless of patient age.⁶³ Adolescents should be made aware of this communicable disease reporting requirement and that they may also be contacted if they test positive as part of public health surveillance activities.

Under Arizona law, information regarding communicable diseases is confidential.⁶⁴ If a minor is deemed capable of consent by law, 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 Abuse and Neglect

Arizona law directs that any physician or other person responsible for the care or treatment of children immediately report "or cause to be reported" to a peace officer or to DCS 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.⁶⁵ Arizona law does not allow a minor to consent to sexual activity with anyone aged 18 years or older.⁶⁶

A clinician does not have to report a minor's evidence or report of sexual activity if the sexual activity involves minors aged 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 knowingly in sexual conduct with a minor less than 15 years old; it is a lesser felony if a minor is 15 or older.⁶⁶ Although Arizona statutes do not obligate clinicians to ask their minor patients about the age of their sexual partner, a clinician must report any known 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. Considerations in prosecution determination include the following: if the activity was consensual; if the victim is aged 15, 16, or 17, and the defendant is less than 19 years of age; or if the defendant is attending high school and is no more than 24 months older than the victim.⁶⁷

Arizona 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 DCS 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.⁶⁸ The statute states 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. Noncustodial parents have no greater rights than custodial parents, and the same statutes discussed above limit noncustodial parents’ rights to obtain their minor child’s confidential medical records.

Cost of Care Considerations

Other than for emergency care, the ability to consent may have consequences for patient confidentiality related to the cost of and payment for 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 they may be responsible for paying for services, and appropriate arrangements should be made. Minors accessing sexual and reproductive health services in Title X-funded clinics with income below 100% of the federal poverty level are eligible to receive services at no cost.

Use of Best Judgment

Clinicians must consistently exercise their best medical judgment, balancing the needs of the minor with ethical and legal considerations. Actions taken should prioritize the minor’s best interest, ensuring that the care aligns with what is deemed beneficial for their health and well-being. Clinicians should thoroughly document their decision-making process to support the care provided, especially if questions arise about the decisions made.



Case Scenarios

Case 1 – Immunizations

Susan, 16, 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 that she needs Tdap, HPV, and MenACWY vaccines.

Can Susan consent to the immunizations without parental consent?

Legally, in Arizona, Susan cannot consent to receive the needed immunizations, and parental consent is required. Only minors in Arizona who are (1) emancipated, (2) married, (3) homeless, or (4) in the military can provide consent to receive their vaccinations.⁴³ In cases where parents disagree regarding immunizations, a court may be willing to intervene upon request.

A handful of states at the time of this writing specifically allow minors of a certain age to consent to HPV and/or Hepatitis B vaccines under the broader umbrella of prevention of sexually transmitted diseases. Some states have also codified laws for mature minor doctrine where if a clinician deems that the minor is mature enough to understand the risk vs. benefits, the minor can receive vaccines without parental consent. Arizona statutes do not currently permit minors to provide consent to immunizations and do not contain a mature minor clause.

Ethically, Susan is mature enough to understand the risks and benefits of immunizations. In addition, the benefits of receiving the immunization outweigh the associated risks.

Practically, there are several ways to obtain parental consent in this situation. Your office can have Susan's mother sign a general consent to treatment form, providing general consent to medical care; however, this would not fulfill the requirement of use of the Vaccine Information Statement (VIS) for each administered immunization. Your office staff may also ask Susan's mother to come in prior to the visit to review the VIS and provide consent, or the VIS and consent can be faxed prior to or during the appointment.

Case 2 – Sexual and Reproductive Healthcare, Explanation of Benefits, and Access to Medical Records

Jennifer, 15, comes in with her mother for evaluation of a persistent headache. When interviewed alone, she reports recent sexual activity. She has one sexual partner and uses condoms most of the time. Her last normal menstrual period was last week. She does not want her mother to know, but she would like oral contraceptives. She also needs routine screening for sexually transmitted infections (STIs). She is on a commercial PPO health plan. You know that her parents will receive an Explanation of Benefits (EOB) from her insurance for the visit and lab tests.

Can she consent to her own care? What do you do about the potential breach of confidentiality from the EOB process?

Legally, Jennifer can consent to testing and treatment of STIs. Regarding 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.⁴⁸

Ethically, it is important to ensure that Jennifer has access to sexual and reproductive education and clinical and preventive services to promote her sexual health. Honoring her request to keep her information confidential can help promote the development of a trusting and safe relationship with her, especially if involving her parents is likely to be a barrier to obtaining medical care.

Practically, clinicians routinely provide family planning services to adolescents without requiring parental consent. However, it is important to make Jennifer aware that if services are billed through her parents' commercial health insurance plan, her parents will likely receive an Explanation of Benefits (EOB) containing information related to the services provided. This is generally not the case for Arizona Medicaid (AHCCCS) and Medicare managed care health plans.

Jennifer should be informed of her available options for accessing care, including paying out of pocket or using insurance while understanding the potential for disclosure through an EOB. For some adolescents, referral to a Title X family planning clinic may provide a more acceptable option for obtaining confidential services.

Jennifer should also be advised that, even when accessing services through Arizona's minor consent laws, with HIPPA protecting and providing her control over the privacy of her records medical records, confidentiality cannot be guaranteed in all circumstances. Arizona's Parents' Bill of

Rights recognizes a parent's right to request and access a minor child's medical records unless otherwise prohibited by law. A.R.S. §§ 1-601 and 1-602.^{58, 71} As a result, there may be circumstances in which parents assert access to information related to services obtained under Arizona's minor consent laws. Ultimately, the specific facts of the situation, along with how applicable federal and state laws are interpreted and implemented by healthcare providers and health systems, will determine the extent to which confidentiality protections are maintained. It is important to recognize a distinction between a minor's ability to consent to services and the ability to maintain information related to those services as confidential.

Ultimately, clinicians must balance legal protections that permit minors to consent to certain healthcare services with applicable state and federal laws, institutional policies, and professional standards regarding adolescent confidentiality. Clinicians should also exercise their best professional judgment in promoting the health, safety, and welfare of the adolescent while fostering trust and supporting family engagement whenever appropriate.

In this instance, you might suggest to Jennifer that involving her mother in this important healthcare decision could be beneficial. Research has demonstrated a positive association between parent-adolescent communication and contraceptive use, and improving communication about contraception and family planning is one strategy for encouraging adolescents' consistent and effective use of contraceptive methods. At the same time, the decision to involve a parent should remain Jennifer's choice unless there are concerns regarding her safety or well-being.

Case 3 – Drug Screening and Substance Use Disorders

Until a few months ago, Jamal, 16, did well in school and was active in student government. His parents noticed that his grades have since deteriorated. He has started skipping school, changed his manner of dress, started spending time with new friends, and been avoiding his family. His mother made an appointment for a checkup and asked your staff to perform a urine drug screen without Jamal's knowledge. You see Jamal 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 use.

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

Legally, there is no Arizona statute that addresses the requirement for a minor's assent to (and therefore knowledge of) drug testing. In a narrow sense of the law, Jamal's assent or knowledge of testing is not necessary in Arizona. If performed, and unless there is some other basis for withholding the records under HIPAA, Jamal's parents can access the drug test results.

Ethically, to build trusting relationships and support adolescents' developing autonomy, a drug screen should generally not be conducted without their knowledge and assent. However, there may be circumstances where clinicians need to assess whether involuntary testing might be in the patient's best interest. Deciding what is best for the patient requires considering several factors, including the adolescent's age, emotional and intellectual maturity, the dynamics of the parent-teen relationship, and the potential seriousness of the medical decision involved.

Practically, the clinician can validate parental concerns regarding a substance use disorder and discuss this with Jamal. He can be informed of his mother's concern regarding behavioral changes and her request that urine drug testing be performed, while also seeking Jamal's perspective on the matter. Confronting Jamal with a positive urine drug test obtained without his knowledge could undermine his trust in both his parents and the clinician. Additionally, drug testing has significant limitations, and a negative test result does not necessarily rule out a substance use disorder. Given Jamal's recent behavioral changes, a mental health evaluation may be warranted regardless of the drug screen results.



Case 4 – Drug Use

Sally, 16, is being seen for a wellness visit. She is a cheerleader, active in student government, and makes excellent grades. Her parents report no specific concerns they would like addressed during the visit. Interviewed alone, Sally reports occasional use of marijuana and alcohol with her friends and denies other drug use. She denies riding in a car with someone high, using drugs or alcohol to relax or feel better, using drugs or alcohol when alone, or forgetting things while using. Her friends have never mentioned that she should cut back, and she has never been in trouble because of alcohol or drugs. She reports no concerns for depression.

How do you counsel Sally? Can you keep information about her occasional use of marijuana and alcohol confidential?

Legally, you are required to break confidentiality to ensure safety if Sally discloses that she is at risk of harming herself or others or if there is a reasonable suspicion of abuse or neglect.

Ethically, Sally is an older teen who appears mature. She is experimenting with marijuana and alcohol and does not appear to have a problematic substance use disorder that poses a significant risk to her or others. Keeping her information confidential could be important in this situation to support building a trusting relationship and ongoing open discussions regarding her alcohol and drug use.

Practically, clinicians are encouraged to discuss confidentiality and its limits with adolescents. Each clinician's assessment of risk may be different, depending on context. In this case, Sally's substance use does not appear to pose an immediate and significant risk to her health and safety. Maintaining confidentiality may be appropriate and may promote ongoing open and honest discussions regarding her use. Parental involvement may be indicated if problematic substance use is identified in the future. The clinician can start by recognizing Sally's achievements and strengths, which can help build rapport and make the discussion more balanced. The clinician can then provide information about the potential risks of using marijuana and alcohol and emphasize the importance of making safe choices, especially in situations like driving or engaging in risky behaviors while under the influence. Having a non-judgmental conversation about her motivations for experimentation with substances and her experiences can help gauge her level of awareness and understanding of the potential consequences. The clinician can also offer information about educational resources regarding alcohol and substances.

Case 5 – Problematic Substance Use

Devon is a 17-year-old who, after a positive confidential Screening to Brief Intervention (S2BI), reports regular misuse of prescription opioids and stimulants for recreation and to treat pain from a sports injury. He has no history of overdose, states that he takes multiple pills daily, and often gets them from friends. He would like to start treatment with Medications for Opioid Use Disorder (MOUD).

How do you counsel him? Should his parents be informed of his substance use disorder?

Legally, Devon does not present while under the influence of a dangerous drug or narcotic (including withdrawal), which may be considered an emergency case where he can be regarded as having consented to needed hospital or medical care.⁴² CFR Part 8 regulations that govern the treatment of opioid use disorder using opioid agonist medications and the accreditation, certification, and treatment standards of opioid treatment programs (OTPs) states that, except in States where State law grants persons under 18 years of age the ability to consent to OTP treatment without the consent of another, no person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant State authority consents in writing to such treatment.⁵³ Devon has a problematic substance use disorder that puts him at significant risk for overdose, and he would benefit from MOUD treatment, for which parental consent is required. His parents must be informed of this recommendation, and their consent must be obtained for treatment.

Ethically, Devon has a serious but treatable opioid use disorder and would benefit from treatment. Because of his substantial risk for overdose and the need for parental consent for him to access MOUD, Devon's parents should be informed of his concern.

Practically, the clinician should commend Devon for his openness and his willingness to start treatment. The clinician should also explain his concern for his safety and his obligation to discuss his diagnosis and treatment options with his parents. To maintain trust and rapport with Devon, the clinician can involve him in developing a plan for sharing the information with his parents and include them as partners in planning for treatment.

Case 6 – Naloxone Dispensing

Imani comes to you seeking a prescription for naloxone. She does not use substances other than occasional cannabis vaping. However, she has heard about fentanyl and counterfeit pills. She would like to be prepared in case she encounters an overdose. She does not want you to discuss her having naloxone with her parents, as they would not approve.

What do you do?

Legally, there are no age restrictions to prescribing or obtaining naloxone, which is available over the counter to adolescents of any age.

Ethically, overdose is preventable, and expanded distribution of naloxone to any adolescent who is at risk is an important part of overdose prevention strategies and can be life saving for Imani and/or her friends.

Practically, naloxone has no age restrictions and is available for adolescents confidentially over the counter and at community distribution sites across Arizona. It is important to discuss the risks of overdose and important harm reduction guidance with Imani and encourage her to have these discussions with her parents. You should offer her naloxone by prescription, dispense directly through clinic, or refer her to a community distribution site, such as health departments or community-based agencies.



Case 7 – Depression

Sam, 16, comes to his school-based clinic for chronic abdominal pain, with his parents having provided general consent to 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 counseling as a next step and schedule a follow-up visit with you in 2 weeks. Sam is reluctant for you to share information about his depression with his parents.

How do you proceed? Can Sam consent to outpatient mental health assessment and counseling?

Legally, Arizona law requires parental consent for outpatient psychological treatment or counseling of minors. However, this requirement is waived in an emergency requiring mental health screening or treatment to prevent serious injury or 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 while emphasizing the benefits of involving his family is important in this situation and can help build a trusting relationship. If Sam reports or exhibits signs of suicidality during a future follow-up visit, the clinician would be obligated to involve his parents against Sam's wishes. However, the clinician is not required to involve his parents against Sam's wishes now, as he does not report acute suicidality.

Practically, Sam needs mental evaluation and treatment. He cannot consent to 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 well-being.

Case 8 – Sexually Transmitted Infections (STI) Treatment

Rosa, 14, is a new patient brought in by her mother for complaints of abdominal pain for several weeks. After obtaining an initial history from the mother and Rosa together, you see Rosa by herself and begin discussing 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. Rosa relates that her parents are strongly opposed to premarital intercourse and have indicated stern disapproval of such behavior. She would like you to keep her information about her diagnosis and treatment confidential, and she expresses concern for her safety should her parents find out.

What do you do?

Legally Rosa may consent to her own evaluation and treatment for a sexually transmitted infection without parental consent. However, clinicians should assess the age of her sexual partner(s) and the circumstances of the relationship to determine whether mandatory reporting requirements apply. Evaluation should include assessment for possible abuse, exploitation, or coercion, and clinicians should remain familiar with applicable reporting laws, institutional policies, and the limits of confidentiality.

Ethically, the clinician must ensure to the best of their ability that Rosa can obtain prescribed medications, attend follow-up appointments, and adhere to treatment recommendations for her health and wellbeing.

Practically, Rosa is a relatively young adolescent and may benefit from the involvement of her parents or another trusted adult to support treatment adherence and follow-up care. Clinicians should explore the reasons for her reluctance to involve her parents, identify supportive adults she may wish to include in her care, and encourage family involvement when it can be done safely and in a manner that preserves trust. If Rosa is unable to do so independently, involving a parent or another trusted adult may be necessary to support her care. Given her concerns about parental discovery, clinicians should discuss potential threats to confidentiality, including Explanation of Benefits (EOBs), medical record access, and patient portal access, and help her develop a safety plan should an inadvertent disclosure occur. Clinicians should also discuss the limits of confidentiality, including mandatory reporting obligations, and explain that any required report would be made to protect Rosa's health, safety, and well-being.

Case 9 – HIV Pre-exposure Prophylaxis (PrEP)

Brix, 16, presents for a wellness visit accompanied by their maternal grandmother, who is their legally authorized representative. During their time alone with you, they indicate being in a new relationship, and they anticipate becoming sexually active with their new partner soon. They express interest in Human Immunodeficiency Virus (HIV) testing and Pre-exposure Prophylaxis (PrEP). However, they have not mentioned this to their grandmother, who they are concerned will not be supportive of the decision.

Can Brix self-consent to HIV Pre-exposure Prophylaxis?

Legally, there is no statute in Arizona specifically addressing minor consent to HIV-related services, including testing, treatment, and preventive services. However, A.R.S § 44-132.01, which allows minors to consent to diagnosis and treatment of STIs, could be interpreted to permit providing HIV testing and treatment services without parental consent.⁴³ In addition to interpreting HIV as included under STI services, biomedical preventive services such as PEP and PrEP can also be interpreted as being included under a broad definition of treatment or services.

Ethically, Brix is mature and making the responsible decision to consider HIV testing and PrEP.

Practically, this scenario requires consultation with relevant stakeholders to determine the offices' interpretation of statutes and to outline their policy on minors' ability to





self-consent for PrEP. If providing HIV-related services confidentially to minors, special attention must be given to how these visits are documented in the medical record and the additional steps that may be needed to limit access to this information and prevent breaches of confidentiality.

You may encourage Brix to include their grandmother in the health care decision and offer yourself as a resource to facilitate the discussion, as prescribing PrEP will require accessing their pharmacy benefits. Depending on their health insurance plan, this may also result in communication being sent to their grandmother regarding prior authorization requests and prescription drug claims. Although PrEP medications can be accessed through manufacturer drug assistance programs, minors are unable to access these assistance programs without a parent or caregiver's approval and signature. Treatment plan adherence can also be enhanced by a parent or caregiver's support and participation.

Additional information on state-level policies on youth access to PrEP can be found [here](#).

Case IO – Emergency Care

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 negative pregnancy test and an ultrasound exam confirm your suspicion of acute appendicitis. She needs emergency surgery, and her parents are not available.

Can you provide 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.

Ethically, Beth is an older adolescent who is consenting to a necessary emergency procedure that benefits her.

Practically, you need to provide emergency surgical care. Efforts should be made to secure consent from a parent or guardian, but emergency care should not be unduly delayed. It is crucial for clinicians to document their efforts to contact the minor's parent or guardian, including the time and method of contact attempts, any responses received, and the rationale for proceeding with treatment without consent.

Case II – Sexual Assault

Itzel, 14, is brought to your community emergency department by the local police for evaluation of sexual assault. She reports being raped two days before reporting to the police. She was spending the weekend with a friend and left her birth control pills at home, reporting that she missed two or three doses. She is worried about getting pregnant and would like emergency contraception. Her parents are out of town, and her 18-year-old brother was asked to watch her while away. Her adult brother does not have authorization to consent to her medical care.

Can you perform her sexual assault evaluation without parental consent? Can she consent to emergency contraception?

Legally, a minor 12 years old or older may consent to treatment for sexual assault evaluation and related treatment if it is not possible to contact the parent or guardian. She is also able to consent to emergency contraception, along with testing and treatment for STIs included in sexual assault evaluations.

Ethically, a timely sexual assault evaluation is in Itzel's best interest. Clinicians should engage the principles of informed consent, reproductive justice, and empower the minor sexual assault victim's autonomy in making decisions related to these sensitive services.

Practically, in providing care to victims of sexual assault, it is important to discuss the difference between general care and forensic examinations needed for criminal investigations. Victims who opt for a forensic evaluation should be referred to the appropriate facility within 72 hours if your site is not designated for forensic examination to ensure a proper chain of evidence. Clinicians should not obtain samples if a patient proceeds with a forensic examination so as not to compromise the chain of evidence.

The U.S. Centers for Disease Control and Prevention (CDC) recommends providing emergency contraception (EC) at the time of sexual assault evaluation. Clinicians should consider the efficacy of levonorgestrel versus ulipristal EC based on the scenario. The levonorgestrel EC (available over the counter and by prescription) has better efficacy when given one to three days after unprotected intercourse, with decreased efficacy on days four and five. Comparatively, ulipristal acetate EC (available by prescription only) has equal efficacy for one to five days after unprotected intercourse. Additionally, ulipristal acetate has better efficacy for those with a higher body mass index (BMI) (within the range of 25 to 30). An IUD is an option for EC but is dependent on the ability to provide the service in an emergency room setting and must take into account the potential for additional psychological trauma.



The CDC recommends STI testing as well as empirical treatment for chlamydia, gonorrhea, and trichomoniasis for sexual assault victims. Baseline serum testing for HIV, syphilis, and Hepatitis B and C are also recommended. While Arizona state law is silent on minors' ability to consent to HIV prevention with PEP, the CDC recommends providing PEP for sexual assault victims despite the minimal risk of HIV transmission with a single episode of penetrative vaginal or anal intercourse. PEP should be prescribed within 72 hours of sexual assault, providing seven days of medication and referral to clinicians who can continue treatment and PEP monitoring.

Clinicians can consult with social work colleagues where available to assist in the social, legal, and psychological aspects of sexual assault care.^{69, 70, 71} In addition to coordinating medical care for follow-up, social workers can help connect victims to victim support services. Minor patients cannot legally consent to mental health services without parental involvement. Law enforcement will involve parents regarding criminal proceedings involving a minor victim.

Case 12 – Pregnancy

Molly, 15, was referred to your obstetric practice for care during her pregnancy, which she has decided to carry to term. She is at 16 weeks' gestation during her first visit and has had no previous prenatal care. She lives with her parents, who are unaware of her pregnancy.

Can Molly self-consent to routine obstetrical care?

Legally, Molly does not meet any of the status exceptions, specifically being emancipated, married, or homeless.⁴³

However, routine obstetrical practice allows minors to consent for prenatal and pregnancy-related care.

Ethically, the care benefits her and the baby.

Practically, Molly needs good prenatal care. Although Arizona statute does not explicitly allow her to self-consent to prenatal care, the routine obstetrical practice in Arizona is to allow for the adolescent to consent to their own prenatal care and all related treatments. This is consistent with other areas of the United States and is the standard of care. However, she is not able to provide consent to care that is not related to her pregnancy.

Case 13 – Abortion

Angie, 16, arrives with her boyfriend, complaining 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. A urine pregnancy test confirms your diagnosis of pregnancy. After explaining and reviewing her pregnancy options, you schedule a follow-up visit in two days to discuss what she has decided. You also strongly encourage her to involve a parent in her decision.

Angie returns for follow-up, indicating that she wants an abortion; she reports having discussed her pregnancy and her desire for an abortion with her parents. She reports that her parents are strongly opposed to her having an abortion. They would like her to carry the pregnancy to term and consider adoption.

Can Angie proceed with an abortion without her parents' consent?

Legally, in Arizona, a physician cannot perform an abortion for a minor without either (1) the written and notarized consent of one of the minor's parents or the minor's guardian or (2) authorization from a judge on the Arizona Superior Court through a process called "judicial bypass."⁵⁶ The process for obtaining a judicial bypass can be found on the Tucson Abortion Support Collective's [website](#).

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

Practically, you can offer a follow-up visit with her and her parents, if both parties are amenable, where you can facilitate a discussion. You can also inform her of Arizona statutes on abortion and the judicial bypass option. You can give her information about the Tucson Abortion Support Collective's website, where she can find additional information and the JB Helpline, (844) 868-2812, which connects her with a lawyer who can assist her through the judicial bypass process.

Case 14 – Confidentiality and Electronic Health Records

James, 17, presents for a wellness visit. He is accompanied by his father. They deny any new health concerns since his last health supervision visit almost two years ago. When interviewed alone, he discloses that he has engaged in oral and anal intercourse with two previous male partners and uses condoms inconsistently. He agrees with your recommendation for comprehensive screening for STIs. He would like this information to be kept confidential.

Your office has developed electronic health record (EHR) functionalities to designate diagnoses, medications, laboratory orders, and results as confidential so they do not appear in his After-Visit Summary (AVS). He is covered under a Medicaid managed care plan that does not send out Explanations of Benefits (EOB) statements. You are unsure what information gets sent to your patient portal, if his parents have proxy access, and what information James and his parents are able to access if they had separate accounts?

Can you keep this confidential? How do you proceed?

Legally, James can consent to his care without parental consent because it relates to testing for STIs.

Ethically, James is an older teen and it is in his best interest to get tested for STIs.

Practically, you must be able to contact James directly with confidential test results, particularly if any screening tests return positive. Obtaining and documenting James's preferred confidential contact information, including whether messages may be left and who else may be contacted

regarding results, is an essential component of providing confidential adolescent healthcare.

Clinical information related to sexual history, sexually transmitted infection (STI) screening, and other confidential services should be documented in a confidential note type, such as an Adolescent Sexual and Reproductive Health Visit note, rather than in a general Adolescent Well Visit note that may be accessible to parents through the medical record or patient portal.

It is also important to understand how information is managed within your electronic health record (EHR) and patient portal. You should determine whether James and his parents have proxy access to a shared patient portal account or separate portal accounts. In traditional proxy-access models, parents and adolescents may view the same health information through a single account. Unless access is terminated, parents often retain portal access until the adolescent reaches adulthood. In such circumstances, confidential information may inadvertently be disclosed depending on what diagnoses, medications, laboratory orders, results, and clinical notes are visible through the portal. An understanding of portal access termination policies and procedures upon request, including whether discontinuing proxy access would affect both the adolescent's and parent's access to the portal before the adolescent reaches 18 years of age, is also important.

To comply with the requirements of the 21st Century Cures Act while protecting adolescent confidentiality, many health systems have transitioned to separate patient and parent portal accounts. These systems can allow different



levels of access based on the account holder and may provide greater protection for confidential adolescent health information. However, clinicians should understand which information is available through each account type, including how sensitive diagnoses, medications, laboratory orders, laboratory results, and clinical notes are displayed, to identify potential confidentiality risks.

In practice, clinicians must balance legal protections that permit minors to consent to certain confidential healthcare services with applicable state and federal laws, institutional policies, and professional standards. While HIPPA provides James with control over the privacy of his records, there is some tension with Arizona's Parents' Bill of Rights which purports to give parent's the right to access a minor child's medical records. A.R.S. §§ I-602.58 Accordingly, clinicians should recognize that James's parents may ultimately attempt to claim access to information regarding his care. Ultimately, the specific facts of the situation, along with how applicable federal and state laws are interpreted and implemented by healthcare providers and health systems, will determine the extent to which confidentiality protections are maintained. Clinicians are encouraged to develop their practice policies and procedures on confidentiality and work closely with their healthcare institution's legal counsel, risk management, compliance, health information management, and information technology teams, where applicable. Clinicians should also become familiar with the capabilities and limitations of their EHR systems, identify potential vulnerabilities that could compromise confidentiality, and advocate for system improvements when needed.

Case 15 – Parental Refusal for Care

Liam is a 17-year-old who checks in to your emergency department accompanied by his girlfriend with right ankle pain. He wants it evaluated. He lives with his parents and is a senior in high school. After an initial medical screening examination required by Emergency Medical Treatment and Labor Act (EMTALA), your registration staff calls his parents and speaks to his mother, who refuses treatment.

Can Liam consent to treatment of his ankle injury?

Legally, he is not an emancipated minor and nor is his care emergent. Parental consent is required for treatment.

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 their reluctance to consent to treatment. This will allow you an opportunity to assess for any concerning family issues. The registered nurse 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 it.

Case 16 – Domestic Minor Sex Trafficking (DMST)

An adolescent girl, Paige, presents to your emergency department 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 clinicians 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 DMST, and you call the local police department. Getting this child the resources she needs will help treat her immediate medical issues (STIs, physical abuse, need for contraception, etc.) 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
- Child can't describe where they are staying, doesn't know city

HISTORICAL FINDINGS:

- › Multiple STIs
- › Previous pregnancy or abortion
- › Frequent visits for emergency contraception
- › Chronic runaway behavior
- › Chronic truancy or problems in school
- › History of sexual abuse, physical abuse, or neglect
- › Involvement of Child Protective Services
- › Lives in foster care or group home
- › Juvenile justice history
- › Significantly older boyfriend
- › Substance use
- › Lack of medical home, frequent emergency department visits

PHYSICAL FINDINGS:

- › Evidence suggestive of inflicted injury
- › Tattoos: sexually explicit; a man's name; gang-affiliated; 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 you 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 17 – Federally funded Title X Family Planning Services

Katie, 14, and her sister, Madison, 16, present to your federally funded Title X clinic to access birth control. They are unaccompanied by their parents or partners and have agreed to come together to support each other. Financially, they qualify for “no charge services” based on income eligibility.

The limits of confidentiality are explained and neither client reports reproductive coercion or non-consensual sexual activity.

After discussion of the various methods of contraceptives available, Katie chooses oral contraceptives and Madison a contraceptive implant. Madison is scheduled to have her contraceptive implant inserted with her next menses, while Katie leaves with a three-month supply 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.

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

Practically, Title X funded clinics are a valuable resource for confidential care for uninsured and underinsured individuals, as well as minor patients seeking reproductive health services. When utilizing Title X services, insured adolescents have the option to access their insurance benefits or receive services based on their income eligibility, where individuals with income below 100% of the federal poverty level are eligible to receive services at no cost. A listing of Title X clinics in Arizona can be found at sexfyi.org.

Case 18 – Addiction

Jordan, 13, is being seen at your emergency department for severe 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 workup 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. You inform her of the results, and she confidentially admits to heavy heroin use for the past three months. You determine that she needs emergent medical stabilization followed by inpatient addiction treatment. Her grandfather does not know about her drug use.

Legally, there is no Arizona statute that addresses the requirement for a minor to be informed of and provide consent/assent for drug testing. In this scenario, drug testing was performed as part of her emergency medical evaluation. Additionally, Jordan is in acute drug withdrawal, which may be considered an emergency, and she can be regarded as having consented to hospital or medical care needed for treatment given her need for emergency medical stabilization. However, the consent of her parents or guardian is necessary to authorize ongoing non-emergency and outpatient care.⁴² CFR Part 8, which includes regulations that govern the accreditation, certification, and treatment standards for treating opioid use disorder using opioid agonist medications in opioid treatment programs (OTPs), states that absent a state law to the contrary, minors cannot be admitted to OTPs without the written consent from a



parent, legal guardian, or responsible adult designated by the relevant state authority.⁵³

Ethically, Jordan is a young adolescent with a serious, potentially life-threatening problem. In this case, it is important to make her guardian aware of her concern and engage him in accessing the care she needs for her opioid use disorder.

Practically, while Jordan can receive acutely needed hospital or medical care, she will not be able to access ongoing non-acute and outpatient substance use disorder treatment without the involvement and consent of her grandfather as her legal guardian.

Case 19 – Young Adult with Intellectual Disabilities Under Guardianship of Parents

RK is a 21-year-old male with Down Syndrome and Mild Intellectual Disability who presents to you for his annual health supervision visit accompanied by his mother who has guardianship for medical health care. Acknowledging that his mother has guardianship, you also recognize the importance of confidentiality to foster honest dialogue and promote independence. In a private conversation with you, he reports being interested sexually in a female friend who also has an intellectual disability. He denies all sexual activity except for

kissing, which she consented to. He also denies unwanted sexual advances.

How do you proceed?

Legally, there is no concern for non-consensual sexual activity or safety. As such, there is no legal requirement to share this information with his guardian.

Ethically, it is important to educate RK about safer sex practices in a way he can understand. With his consent, it may also be helpful to include his mother in some portion of the visit where you can model for her discussions that normalize his sexual feelings and desires and your recommendations. Doing so may also help engage his mother in providing education about healthy (vs. unhealthy) relationships and behaviors and provide ongoing guidance and support at home.

Practically, documenting sensitive information obtained with RK in private in his medical record that his mother has access to as his guardian bears potential for breach of confidentiality.



Appendices

Appendix A: Additional Resources

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

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

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

Appendix B: Arizona Revised Statute 26-2272

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

- 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.
- 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.
- A person who violates this section is guilty of a class I misdemeanor.
- For the purposes of this section, "parent" means the parent or legal guardian of a minor child.

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