State-by-State Variability in Adolescent Privacy Laws

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abstract

OBJECTIVES: Health care providers managing the complex health needs of adolescents must comply with state laws governing adolescent consent and right to privacy. However, these laws vary. Our objectives were to summarize consent and privacy laws state-by-state and assess the implications of variation for compliance with the 21st Century Cures Act and with evidence-based guidance on adolescent care.

METHODS: We summarized state laws and regulations on minor consent for the following: health services, substance abuse treatment, prenatal care, mental health care, contraceptive management, immunizations, sexually transmitted infection management, human immunodeficiency viruses testing and treatment, dental care, and sexual assault evaluation. We compared state laws and regulations with American Academy of Pediatrics' evidence-based guidelines to assess consistencies in guidance.

RESULTS: We observed notable state-by-state variability in laws governing consent for adolescent patients. No states had identical policies for all services studied. For example, although all states had provisions for consent to management of sexually transmitted infections, there were variable specifications in the age and type of minor, whether this includes human immunodeficiency viruses, and whether confidentiality is protected. Providing confidential care to the adolescent patient has been set as a priority by medical societies; however, guidelines are limited by the need to comply with state laws and regulations.

CONCLUSIONS: State laws on consent and privacy for adolescents are highly variable, and many do not reflect pediatric professional standards of care. This inconsistency is a barrier to operationalizing a consistent and equitable experience providing evidence-based medical care and ensuring adolescent privacy protection.

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WHAT'S KNOWN ON THIS SUBJECT: States have independently developed laws and regulations on adolescent consent and privacy around healthcare access based on age and the type of care the adolescent is seeking. These laws and regulations are complex and vary from state to state.

WHAT THIS STUDY ADDS: This study highlights variability in state consent laws, which complicates their interpretation and management when intersecting with HIPAA regulations, the 21st Century Cures Act, and evidence-based care recommendations for protecting health data privacy and the protection of adolescent health information.

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A rich evidence base demonstrates that adolescents are more likely to seek health care for potentially sensitive issues such as sexuality, mental health, and drug use if they can provide their own consent and be confident that their health information is private.[1–8] However, parents and guardians also have responsibilities pertaining to care for minor patients. Long-established state laws are often inconsistent in how they address these conflicting objectives, resulting in varying regulations from state to state.[9,10] For example, adolescents in some states can consent to their own healthcare if they have reached a certain age or are parents themselves, and in others, they can only consent to specific types of sensitive healthcare within the domains of reproductive health, sexually transmitted illnesses (STIs), or substance abuse. There are also persisting inconsistencies in privacy and confidentiality protection by state.[10–14] Although the best clinical practices to support adolescent autonomy should transcend state lines, state law variations make it nearly impossible to provide the privacy protection that is supported by medical societies, including the American Academy of Pediatrics (AAP), to support adolescent autonomy.

Adolescent privacy concerns have increased with the expanded use of electronic health records (EHRs), as well as with the advent of Open Notes[15] and the 21st Century Cures Act, which has a focus on increasing electronic health information and reducing information blocking.[16,17] In general, when there is a conflict between the state and federal laws, the state laws take precedence. However, this is not a consistent hierarchy and is complicated by variable state laws.

Collectively, these efforts have increased the transparency of health records and made them more available to patients and caregivers, such as parents or guardians. Unprecedented access to electronic health information raises the potential for breaches of privacy laws and confidentiality regulations.[18] Also, with increasing EHR interoperability, the data collected under the laws of 1 state may be transferred to other states with different laws. It is often the responsibility of health care providers to ensure that medical consent and access to health information is done in compliance with state and federal laws, yet providers are often unaware of what services a minor can access confidentially according to state laws.[19]

EHRs have not yet consistently developed the ability to reliably protect sensitive information, particularly when transferring from 1 state to another.[20–24] Due to the complexities of providing privacy protection that complies with complex state laws, some medical centers have shut down health information access during adolescence.[10] This creates inequities in access to health care information for adolescents at a time of unique medical vulnerability.[25–30]

Our objectives were to summarize state-by-state adolescent consent laws to illustrate variability of policies, and to examine these laws in the lens of evidence-based guidance and expert consensus about optimal care for adolescents. Although the AAP values and promotes the provision of confidential healthcare for adolescent patients, guidance on the practical details of consent and privacy protection generally defers to state laws and regulations.[29,31–35]

METHODS

We used a variety of sources to construct Table 1, which provides a summary of state-by-state minor consent policies for the following services: general medical care, immunizations, dental care, sexual assault evaluation, STI testing and treatment, human immunodeficiency viruses (HIV) testing and treatment, contraceptive care, prenatal care, substance abuse treatment, and mental health care.

We consulted Minor Consent to Medical Treatment Laws published by the National District Attorneys Association,[36] Consent Laws: A Summary, third Edition[13] authored by Abigail English, and additional resources specific to each state to identify relevant codes and statutes. Then we consulted the current state statutes and codes listed in Table 2 to include the most up to date consent policies. We also validated our interpretations of current laws and regulations through the following regularly updated resources: Guttmacher Institute Web site,[37–39] SchoolHouse Connection's *Minor Consent for Routine Medical Consent*,[40] *VAXTEEN Consent Laws by State*,[41] and *Kaiser Family Foundation*.[42] Using these resources, we were able to put together a comprehensive table of current policies regarding minor consent and privacy.

Using guidelines and policy papers developed by the AAP, we explored whether evidence-based standards of care were consistent with state policies.[31–33,43]

RESULTS

State-to-State Variability

Table 1 includes summary information of state laws for consent and privacy around each of the study topics (see Table 2 for sources). The regulations regarding consent for health services varied and were, at times, complex and unclear. At times, consent polices were not specified and needed to be

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TABLE 1. State-by-State Policies on the Ability for Minors to Consent for Medical Services

State	General Medical Care	Immunizations (see Figure 2)	Dental Care	Sexual Assault Evaluation	STI Testing and Treatment	HIV Testing and Treatment	Contraceptive Care	Prenatal Care	Substance Abuse Treatment	Mental Health Care
Alabama	If 14 or older or graduated high school, ever married or pregnant Age of maturity is 19	Yes, if 14 or older or graduated high school	14 or older or graduated high school, ever married or pregnant	No explicit policy	Yes, if 12 or older[a]	Yes, if 12 or older[a]	14 or older or graduated high school, ever married or pregnant	Yes	Yes	14 or older or graduated high school, ever married or pregnant
Alaska	If emancipated, living apart and financially independent, married or parents Otherwise, if parent cannot be contacted or unwilling to give consent	Yes, if parent cannot be contacted or won't grant consent	If emancipated, living apart and financially independent, married or parents Otherwise, if parent cannot be contacted or unwilling to give consent	No explicit policy	Yes	No	Yes	Yes	No explicit policy	No explicit policy
Arizona	If emancipated, married, or homeless	No, unless court ordered	No	Yes, if 12 and older	Yes	No	Yes	No explicit policy	Yes, if 12 or older	No explicit policy
Arkansas	If emancipated, married, incarcerated, or if have sufficient intelligence to appreciate the consequences of treatment	Yes, if mature minor	No explicit policy	No explicit policy	Yes[a]	No	Yes	Yes	If they have sufficient intelligence to appreciate the consequences	If they have sufficient intelligence to appreciate the consequences
California	If 15 or older, living separately and financially independent, or 12 or older if in contact w/ infectious, contagious, or communicable disease	Yes, if 12 or older for HPV, Hep B (or COVID-19 in San Francisco)	15 or older	Yes, if 12 or older	Yes, if 12 or older	Yes, if 12 or older	Yes	Yes	Yes, if 12 years or older[a]	Yes,[a] if 12 years or older and is mature enough to participate intelligently and is in present danger or victim of incest or child abuse
Colorado	If 14 or older, living separately and financially independent	No	If 14 or older, living separately and financially independent	Yes	Yes, if 13 or older	Yes, if 13 or older[a]	Yes	Yes	Yes	Yes, if 15 or older[a]
Connecticut	If emergency case, emancipated or married	No	Yes, if married, or emancipated minor, or a parent.	No explicit policy	Yes, physician must report positive result if younger than 12	Yes, physician must report positive result if younger than 12	Yes, if married	No explicit policy for unmarried minors	Yes	Yes
Delaware	If married, pregnant, in an emergency, or 12 or older with infectious diseases	Yes, if 12 and older, except COVID-19	Yes, if married or pregnant	No explicit policy	Yes, if 12 or older[a]	Yes, if 12 or older[a]	Yes, if 12 or older[a]	Yes, if 12 or older[a]	Yes, if 14 or older for outpatient	No explicit policy
Florida	If 16 or older and emancipated, or married, homeless, or living apart and financially independent	No	16 or older and emancipated, or married, homeless, or living apart and financially independent	No explicit policy	Yes	Yes	Yes, if married, a parent, pregnant or ever pregnant	Yes	Yes	Yes, if 13 and older
Georgia	If emancipated or married	No	Yes, for emancipated minor	No explicit policy	Yes[a]	Yes[a]	Yes	Yes	Yes[a]	No explicit policy
Hawaii	If 14 or older, not under the control of a legal guardian, with informed consent, and care is for minor's benefit	no	14 or older, not under the control of a legal guardian, with informed consent, and care is for minor's benefit	No explicit policy	Yes, if 14 or older[a]	No	Yes, if 14 or older[a]	Yes, if 14 or older[a]	Yes[a]	Yes, if 14 or older
Idaho	If able to comprehend the nature of and risks of treatment	Yes, if mature minor	If able to comprehend the nature of and risks of treatment	If able to comprehend the nature of and risks of treatment	Yes, if 14 or older	Yes, if 14 or older	Yes	Yes	Yes,[a] info may be shared with parent if younger than 16	Yes, if 14 or older
Illinois	If 14 and older and emancipated, understands	Yes, if 12 or older for HPV or Hep B	Emergency dental care	Yes	Yes, if 12 or older[a]	Yes, if 12 or older[a]	Yes, if married, a parent, pregnant or	Yes	Yes, if 12 or older	Yes, if 12 or older

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	benefits and risks, identified by a listed representative, or married, pregnant or a parent						ever pregnant, or referred			16 or older for inpatient[a]
Indiana	If emancipated, 14 years old and financially independent and living apart from parents, married, or in the military.	No	No explicit policy	Yes	Yes	No	Yes, if married	No explicit policy for unmarried minors	Yes	No explicit policy
Iowa	If 16 or older and emancipated, or married, or incarcerated as an adult	Yes, if 12 or older for HPV or Hep B	No explicit policy	Yes, treatment information cannot be kept confidential from parent	Yes	Yes - parent must be notified for a positive result	Yes	No explicit policy for unmarried minors	Yes	No explicit policy for general mental health; may consent to immediate or short-term mental health services if a victim of sexual assault or sexual abuse
Kansas	16 or older	No	Yes if, 16 or older	Yes	Yes[a]	No	Yes, if mature minor	Yes, if mature minor	Yes	No explicit policy
Kentucky	If emancipated, married, or parent	No	If emancipated, married, or parent	Yes	Yes[a]	Yes	Yes[a]	Yes[a]	Yes[a]	Yes, if 16 or older[a]
Louisiana	Yes	Yes, except COVID-19	No explicit policy	No explicit policy	Yes[a]	No	Yes, if married	No explicit policy for unmarried minors	Yes[a]	No explicit policy
Maine	If living independently, or married, or in the Armed Forces, or emancipated	No	If living independently, or married, or in the Armed Forces, or emancipated	Yes	Yes[a]	No	Yes[a]	Yes[a]	Yes[a]	Yes[a]
Maryland	If married, a parent, living independently, or in an emergency	No	If married, a parent, living independently, or in an emergency	Yes	Yes[a]	No	Yes[a]	Yes[a]	Yes[a]	Yes, a minor 12 years or older[a]
Massachusetts	If emancipated, living apart from parents, ever married, pregnant, or a parent; or has a disease dangerous to public health	No	If emancipated, living apart from parents, ever married, pregnant, or a parent; or has a disease dangerous to public health	No explicit policy	Yes, parent must be notified if minor's health or life at risk	No	Yes, not through state funding	Yes, parent must be notified if minor's health or life at risk	Yes, if 12 or older	Yes, if 16 or older
Michigan	If emancipated, living apart from parents, ever married, pregnant, or a parent	No	If emancipated, living apart from parents, ever married, pregnant, or a parent	Yes	Yes[a]	Yes[a]	Yes, if married	Yes[a]	Yes, if 14 or older	Yes, if 14 or older
Minnesota	If living independently, married, pregnant, a parent, or in an emergency	Yes, only for Hep B	If living independently, married, pregnant, a parent, or in an emergency	No explicit policy	Yes[a]	No	Yes[a]	Yes[a]	Yes[a]	Yes, if related to pregnancy, venereal disease, or alcohol & other drug abuse
Mississippi	If married or emancipated	No	No explicit policy	No explicit policy	Yes	Yes, but does not include treatment	Yes, if married or a parent or referred	Yes	Yes, if 15 or older[a]	No explicit policy
Missouri	If married, parent, or pregnant	No	No explicit policy	Yes	Yes[a]	No	Yes, if married	Yes[a]	Yes[a]	No explicit policy
Montana	If emancipated, married, a parent, graduated from high school, or living apart from parents	Yes, if married, a parent, or graduated high school, except for COVID-19	Yes, if delay in care would endanger health	No explicit policy	Yes[a]	Yes	Yes[a]	Yes[a]	Yes[a]	Yes, if 16 or older
Nebraska	No explicit policy[a] Age of maturity is 19	No	No explicit policy	No explicit policy	Yes	No	Yes, if married	No explicit policy	Yes	No explicit policy
Nevada	If living apart from parents, ever married, parent, or health emergency	No	If living apart from parents, ever married, parent,	No explicit policy	Yes	Yes	Yes, if married, a parent or a mature minor	Yes, if married or mature minor	Yes	No explicit policy

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			or health emergency							
New Hampshire	Emergency care	No	No explicit policy	No explicit policy	Yes, if 14 or older	No	Yes, if mature minor	Yes, if mature minor	Yes, if 12 or older	No explicit policy
New Jersey	If married or pregnant	No	No explicit policy	Yes, if 13 or older	Yes[a]	Yes, 13 or older[a]	Yes, if married, pregnant or ever pregnant	Yes[a]	Yes	Yes, 16 or older for outpatient services, excluding medications
New Mexico	If 14 years with capacity to give consent and living apart from parents, or a parent	No	If 14 years with capacity to give consent and living apart from parents, or a parent	No explicit policy	Yes	Yes, but does not include treatment	Yes	Yes	Yes, if 14 or older, parents notified if psychotropic medications given	Yes, if 14 or older, parents notified if psychotropic medications given
New York	If parent, married, or in an emergency	Yes, only for HPV	If parent, married, or in an emergency	Yes	Yes	Yes, but does not include treatment	Yes, not through state funding	Yes	Yes[a]	Yes[a]
North Carolina	If married, or 16 or older and emancipated, or for emergency care	Yes, except for those with emergency use authorization	No explicit policy	No explicit policy	Yes	Yes	Yes	Yes[a]	Yes	Yes
North Dakota	Yes, for emergency care.	No	Yes, if 14 and homeless	Yes	Yes, if 14 or older	Yes, if 14 or older	No explicit policy	Yes, during first trimester and first visit after first trimester	Yes, if 14 or older	No explicit policy
Ohio	No explicit policy	No	No explicit policy	Yes	Yes	Yes, but does not include treatment	No explicit policy	No explicit policy	Yes	Yes, if 14 or older
Oklahoma	Yes, in an emergency or if married, emancipated, living apart, or has had a pregnancy.	No	Yes, in an emergency or if married, emancipated, living apart, or has had a pregnancy.	Yes	Yes[a]	Yes[a]	Yes, if married, pregnant or ever pregnant[a]	Yes[a]	Yes, in an emergency or if married, emancipated, living apart, or has had a pregnancy. 16 years or older for inpatient treatment	Yes, in an emergency or if married, emancipated, living apart, or has had a pregnancy. 16 years or older for inpatient treatment
Oregon	If 15 or older	Yes, if 15 or older	Yes, if 15 or older	No explicit policy	Yes	Yes	Yes*	Yes, if 15 or older*	Yes,[a] outpatient: 14 or older inpatient: 15 or older	Yes,[a] outpatient: 14 or older inpatient: 15 or older
Pennsylvania	If married, emancipated, pregnant, or graduated from high school.	No, unless 11 and older for COVID-19 in Philadelphia, and able to consent	Yes, if minor is emancipated or has graduated high school, been married or been pregnant.	Yes	Yes	Yes	Yes, if 14 or older	Yes	Yes[a]	No explicit policy
Rhode Island	If 16 or older for certain services	Yes, if 16 or older	No explicit policy	No explicit policy	Yes	Yes	No explicit policy	No explicit policy	Yes	No explicit policy
South Carolina	If 16 or older	Yes, if 16 or older	Yes, if deemed medically necessary	No explicit policy	Yes, if 16 or older or mature minor	Yes, if 16 or older or mature minor	Yes, if 16 or older, mature minor or married	Yes, if 16 or older, or mature minor	Yes, if 16 or older, younger when deemed necessary	Yes, if 16 or older, younger when deemed necessary
South Dakota	If married or emancipated	No	No explicit policy	Yes, if 16 or older	Yes	No	Yes, if married	No explicit policy for unmarried minors	Yes	No explicit policy
Tennessee	If 16 years or older	Yes, if 14 or older, and mature minor	Yes, 14 or older for numerous situations	No explicit policy	Yes	Yes	Yes	Yes	Yes[a]	Yes, if 16 or older
Texas	If 16 years or older	No	Yes, if 16 or older and lives separate from parents or guardians	Yes	Yes[a]	Yes[a]	Yes, if married	Yes[a]	Yes,[a] inpatient: 16 or older	Yes
Utah	If emancipated, married, a parent, or an unaccompanied homeless minor who is 15 years or older	No	No explicit policy	No explicit policy	Yes	No	Yes, if married	Yes	No explicit policy	No explicit policy
Vermont	If emancipated or married	No	No explicit policy	Yes	Yes, if 12 or older	Yes, if 12 and older, but does	Yes, if married	No explicit policy for	Yes, if 12 or older	Yes,[a] outpatient:

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						not include treatment		unmarried minors		any age inpatient: 14 or older
Virginia	If emancipated, married or a parent	No	If emancipated, married, or parent.	No explicit policy	Yes	Yes	Yes	Yes	Yes, for outpatient treatment	Yes, for outpatient treatment
Washington	If emancipated, married, or meets criteria for being homeless	Yes, if mature minor	No explicit policy	No	Yes, if 14 or older	Yes, if 14 or older	Yes	Yes	Yes, if 13 or older for outpatient treatment	Yes, if 13 or older for outpatient treatment
West Virginia	If 16 and emancipated or married	No	No explicit policy	No explicit policy	Yes	No	Yes, if married	Yes, if 16 or older and married or a mature minor	Yes	Yes, if 14 or older
Wisconsin	No explicit policy	No	No explicit policy	Yes	Yes	No	No explicit policy	No explicit policy	Yes,[a] if 12 years or older and the parent cannot be found. The parent or guardian must be notified at soon as possible.	Yes, if 14 or older
Wyoming	If emancipated, is or was married, in the military, or living apart from parents and managing their own affairs	No	No explicit policy	Yes, if parent or guardian cannot be located	Yes	Yes	Yes, not through state funding	No explicit policy for unmarried minors	Yes,[a] if 12 or older and is a smoker or user of tobacco products	No explicit policy

STI, sexually transmitted infection; HIV, human immunodeficiency virus.

[a] Parent/guardian may be informed.

Data sources for this table are found in Table 3. The information in this table may not be the most updated, accurate or complete.

inferred from general medical care laws. We found that limited numbers of states had explicit policies that allowed routine minor consent for the services in our table (Fig 1). There was a wide diversity in laws and regulations, with variability in the minimum age of consent, the types of minors that may consent, and the contexts within which consent is permitted. No 2 states had the same consent regulations for all the services. Parameters that influenced the ability to consent included marriage, divorce, pregnancy, minors living apart from their parents and managing their own financial affairs, incarceration, military service, treatment circumstances, services provided, and type of infections.

Nonsensitive Health Care

Almost all states set the age of maturity at 18 years; however, 2 states (Alabama and Nebraska) set it at 19 years. Eighteen states allowed adolescents to consent for immunizations; however, all had specifications related to the age of the patient, status of the minor, or type of immunizations provided (Fig 2). Many states lacked a clear policy on the ability to consent for routine dental care ($n = 19$).

Sensitive Health Care

Generally, sensitive health services, such as substance abuse, mental health, STI, and reproductive services, can be independently consented to by minors.[13] However, we found that specifics surrounding these policies varied and, at times, were unclear. Most states allowed minors to consent for substance abuse treatment; however, 2 states left this unclear, and 15 had minimum age requirements. For mental health treatment, many states had no explicit laws for minor consent ($n = 19$), and the existent laws varied in the ages of consent. For sexual assault evaluations, about half had no explicit policy or did not permit minors to consent ($n = 26$). While all states had some provisions allowing for management of STIs, many had limitations: for example, 12 had minimum age requirements, 5 allowed minors to consent for testing only, and 1 required any positive results to be reported to the parent for patients under 12 (Fig 3). There was variability in whether STI services included HIV: slightly more than half ($n = 27$) allowed minors to consent for testing and treatment, while several allowed for testing alone ($n = 5$). For contraceptive care, almost half of the states allowed only specific categories of minors to consent ($n = 24$), and 4 had no explicit laws regarding consent for this type of care. Most states allowed minors to consent for prenatal care; however, 12 lacked explicit policies.

In addition to variability in the ability to consent, states with laws pertaining to sensitive health care also demonstrated variability in privacy protection. Twenty states permitted providers to share information on access to STI services with the parent or guardian, 8 permitted the disclosure of information related to contraceptive services, 14 for

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TABLE 2 Sources of Data Used for Table 1

State	Codes and statutes	Additional sources per state
Alabama	AL Code §§ 22-8-4, 22-8-5, 22-8-6, 22-8-7, 22-11A-19, 26-1-1, 26-13-1	https://www.alabamapublichealth.gov/familyplanning/assets/minor-consent-guide.pdf
Alaska	AK Stat §§ 09.55.590, 25.05.171, 25.20.010, 25.20.020, 25.20.025	http://www.touchngo.com/lglcntr/akstats/statutes/title25/chapter20/section025.htm
Arizona	AZ Rev Stat §§ 1-215, 13-1413, 36-663, 36-2024, 44-132, 44-132.01, 44-133.01	https://cdn.ymaws.com/www.azmed.org/resource/resmgr/Publications/2015_Adol_Consent_Conf_Bookl.pdf
Arkansas	AR Code §§ 9-25-101, 9-26-104, 20-9-602, 20-16-302, 20-16-304, 20-16-508	https://www.schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care/
California	CA Fam Code §§ 6922, 6924-6929	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=FAM&sectionNum=6922.
Colorado	CO Rev Stat §§ 13-22-102, 13-22-103, 13-22-103.5, 13-22-105, 13-22-106(1), 25-4-1405(6), 27-65-103(2), 27-81-109, 27-81-110, 1008-1	https://www.coloradohealth.org/sites/default/files/documents/2017-05/Colorado_Minor_Consent_Law_Quick_Reference_Chart.pdf
Connecticut	CT Gen Stat §§ 1-1d, 19-13-D3	https://www.womenshealthct.com/media/5afpkm1n/whtr-rights-of-minors.pdf https://www.cga.ct.gov/searchresults.asp?cx=005177121039084408563%3Ahs1zq3ague8&ie=UTF-8&cof=FORID%3A10&q=minor+consent&submission=%EF%80%82
Delaware	13 DE Code §§ 707, 710, 16 DE Code § 2210	http://delcode.delaware.gov/title13/c007/sc01/index.html
Florida	FL Stat §§ 394.4784, 743.01, 743.015, 743.064, 743.065, 743.067	https://www.flsenate.gov/Laws/Statutes/2012/743.0645 https://www.medicaleconomics.com/view/florida-consent-issues
Georgia	GA Code §§ 19-7-1, 31-17-7, 37-7-8	https://www.gaaap.org/wp-content/uploads/2012/02/minors%20access%20card%20ga%20%2008%202011.pdf
Hawaii	HI Rev Stat §§ 577D-1, 577D-2, 577A-2	https://health.hawaii.gov/camhd/files/2021/02/Minor-Mental-Health-Consent-Law.pdf
Idaho	ID Code §§ 15-1-201, 16-2403, 18-603, 32-101, 37-3102, 39-3801, 39-4503, 39-4504; 66-318	https://legislature.idaho.gov/statutesrules/idstat/
Illinois	77 IL Admin Code §§ 693.130, 697.20, 410 ILCS 70/5, 210/1-5	https://www.team-iha.org/files/non-gated/legal/consent-by-minors.aspx?ext=.#
Indiana	IN Code §§ 12-23-12-1, 16-21-8-3, 16-36-1-3, 16-41-6-1	https://nahic.ucsf.edu/wp-content/uploads/2019/01/Indiana-AYAH-Confidentiality-Guide_Final.pdf
Iowa	IA Code §§ 125.33, 141A.7, 147A.10, 232C.1, 599.1, 915.35	https://nahic.ucsf.edu/wp-content/uploads/2019/01/Iowa-AYAH-Confidentiality-Guide_Final.pdf https://idph.iowa.gov/Portals/1/Files/FamilyHealth/adolescent_law.pdf
Kansas	KS Stat §§ 38-109, 38-123, 38-2316	http://www.kslegislature.org/li_2014/b2013_14/statute/038_000_0000_chapter/038_001_0000_article/038_001_0023b_section/038_001_0023b_k/ https://codes.findlaw.com/ks/chapter-38-minors/ks-st-sect-38-2316.html
Kentucky	KY Rev Stat. §§ 214.185, 216B.400	https://codes.findlaw.com/ky/title-xviii-public-health/ky-rev-st-sect-214-185.html
Louisiana	LA Rev Stat §§ 40:1079.1, 40:1079.2, 40:1079.13	https://codes.findlaw.com/la/revised-statutes/la-rev-stat-tit-40-sect-1079-1.html
Maine	22 ME Rev Stat §§ 1502, 1503	https://mainefamilyplanning.org/wp-content/uploads/2020/07/MFP_MinorsRights_Brochure_web-1.pdf, https://legislature.maine.gov/statutes/22/title22ch260.pdf https://www.mainelegislature.org/legis/statutes/22/title22sec1503.html
Maryland	MD Health-Gen Code §§ 20-102	https://www.modernfamilylawfirm.com/marylands-new-law-allows-12-year-old-children-to-consent-to-mental-health-treatment/ https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=20-102 https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/PDF%20Manual/Section%20VII/MD%20Minor%20Consent%20Laws%2010%2026%2012.pdf
Massachusetts	MA Gen L ch 112, §§ 12e1/2, 12f, 123 § 10, Code of Regs 11.06, 11.08, 11.09, 11.10, 11.16, 27.06	https://www.mass.gov/info-details/guide-on-the-disclosure-of-confidential-information-health-care-information
Michigan	MI Comp L §§ 330.1707, 333.5127, 333.5133, 333.9132, 722.623	https://www.umhs-adolescenthealth.org/wp-content/uploads/2019/05/confidentiality-laws-mi-spark-handout.pdf https://www.michigan.gov/documents/mdch/Michigan_Minor_Consent_Laws_June20093_392440_7.pdf https://www.networkforphl.org/resources/minors-health-privacy-michigan/
Minnesota	MN Stat §§ 144.341, 144.342, 144.343, 144.3441	https://nahic.ucsf.edu/wp-content/uploads/2019/01/Minnesota-AYAH-Confidentiality-Guide_Final.pdf https://www.revisor.mn.gov/statutes/cite/144.343 https://www.health.state.mn.us/people/adolescent/youth/confidential.html
Mississippi	MS CODE §§ 41-41-3, 41-41-14	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf

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TABLE 2 Continued

State	Codes and statutes	Additional sources per state
Missouri	MO St. §§431.061, 431.065.1, 431.063, 595.220	https://health.mo.gov/living/families/adolescenthealth/pdf/MissouriMinorConsentLaws1-4-19.pdf
Montana	MT Code §§ 41-1-402, 53-21-112	https://leg.mt.gov/bills/2005/mca/41/1/41-1-402.htm https://leg.mt.gov/bills/mca/title_0410/chapter_0010/part_0040/section_0050/0410-0010-0040-0050.html
Nebraska	NE Code § 71-504	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf
Nevada	NRS §§ 129.030 129.050, 129.060	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf
New Hampshire	NH Rev Stat §§ 135-C:12, 141-C:18, 141-F:5, 153-A:18, 318-B:12	https://nahic.ucsf.edu/wp-content/uploads/2019/01/New-Hampshire-AYAH-Confidentiality-Guide_Final.pdf
New Jersey	NJ Rev Stat §§ 9:17A-4, 9:17A-1, 9:17B-1	https://nahic.ucsf.edu/wp-content/uploads/2019/01/New-Jersey-AYAH-Confidentiality-Guide_FINAL.pdf
New Mexico	NM Stat §§ 24-1-9, 24-1-13, 24-2B-3, 24-7A-6.2, 24-8-5, 32A-6A-15	https://nahic.ucsf.edu/wp-content/uploads/2019/01/New-Mexico-AYAH-Confidentiality-Guide_FINAL.pdf
New York	NY PHL §§ 2305, 2311, 2504, 2780(5), 2781, Ment Hygiene L § 33.21, 10 NY Comp Codes Rules and Regs § 23.4	https://www.nyclu.org/sites/default/files/thl.pdf https://ceitraining.org/documents/AIS%20Consent%20Guide%2011%2017%2015%20FINAL%201%2011%202016.pdf https://www.nyclu.org/en/rrp-minors-and-rape-crisis-treatment-qa https://www.health.ny.gov/professionals/ems/pdf/99-09.pdf https://www.health.ny.gov/professionals/ems/policy/99-09.htm
North Carolina	NC Gen Stat §§ 7B-3500, 90-21.1; 90-21.5, 90-21.9	https://www.ncleg.net/enactedlegislation/statutes/html/bysection/chapter_90/gs_90-21.5.html
North Dakota	ND Cent Code §§ 14-10-17, 14-10-19	https://casetext.com/statute/north-dakota-century-code/title-14-domestic-relations-and-persons/chapter-14-10-minors/section-14-10-19-minors-consent-for-prenatal-care-and-other-pregnancy-care-services
Ohio	OHIO REV CODE §§ 3109.01, 3701.242, 3709.241, 3719.012	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf
Oklahoma	OK STAT §§ 43A-5-503. 63-1-532.1, 63-2601, 63-2602	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf
Oregon	OR Rev Stat §§ 109.510, 109.610, 109.640, 109.675	https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/Documents/minor-rights.pdf
Pennsylvania	PA STAT §§ 35-10101, 35-10101.1, 35-10103, 35-10104, Code §27.97	https://www.aclupa.org/en/reference-card-minors-access-confidential-health-care-pennsylvania
Rhode Island	RI GEN L §§ 14-5-4, 23-4.6-1, 23-8-1.1	https://schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care/
South Carolina	SC Code §§ 63-5-330, 63-5-340, 63-5-350	https://www.scstatehouse.gov/code/t63c005.php
South Dakota	SD CODIFIED L §§ 20-9.4-2, 25-5-24, 25-5-25, 26-1-1, 34-20A-50, 34-23-16	https://sdlegislature.gov/Statutes/Codified_Laws/2047349
Tennessee	TN Codes §§ 63-6-220, 63-6-222, 63-6-223, 68-34-107	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf
Texas	TX Health & Safety Codes §§ 81.041, 572.001, 572.002, 773.008, TX Fam Codes §§ 32.003, 32.004	https://nahic.ucsf.edu/wp-content/uploads/2019/01/Texas-AYAH-Confidentiality-Guide_Final.pdf https://www.txhealthsteps.com/static/warehouse/1076-2011-Apr-20-n54e12w0v5j3bkke32k3/section_2.html#
Utah	UT CODE §§ 15-2-1, 26-6-18, 26-10-9, 62A-15-301, 78A-6-802, 78A-6-803, 78A-6-805, 78B-3-403, 78B-3-406	https://le.utah.gov/xcode/Title26/Chapter6/26-6-S18.html https://law.justia.com/codes/utah/2012/title-26/article-10/section-9
Vermont	12 VSA §§ 7151, 18 VSA §§ 4226, 7503, 8350	https://nahic.ucsf.edu/wp-content/uploads/2019/01/Vermont-AYAH-Confidentiality-Guide_Final.pdf
Virginia	VA CODE §§ 16.1-331, 16.1-333, 16.1-334, 54.1-2969	https://law.lis.virginia.gov/vacode/54.1-2969/
Washington	WA Rev. Code §§ 7.70.050, 9.02.100, 13.64.010, 13.64.060, 26.28.020, 70.24.110, 70.24.017, 70-96A.095, 71.34.030, 71.34.530	https://nahic.ucsf.edu/wp-content/uploads/2019/01/Washington-AYAH-Confidentiality-Guide_FInal.pdf https://depts.washington.edu/uwhatc/PDF/guidelines/Recommended%20Guidelines-2017-adult.pdf
West Virginia	WV Code §§ 16-4-10, 27-4-1,60A-5-504	http://www.courtswv.gov/public-resources/guardians-treatment-of-minors.html
Wisconsin	WI Stat §§ 51.13, 51.14, 51.45, 51.47, 51.61 146.82	https://www.uwhealth.org/files/uwhealth/docs/pdf6/minors_legal_grid.pdf
Wyoming	WY Stat §§ 6-2-309, 14-1-101, 14-1-102, 14-3-402, 35-4-131	https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf

These codes may not be the most recent versions. Immunization resources: VAXTEEN. Consent Laws by State.[41] Kaiser Family Foundation. State Parental Consent Laws for COVID-19 Vaccination.[42] Sensitive care resources: Guttmacher Institute, An Overview of Minor's Consent Laws,[37] Guttmacher Institute. Minor's Access to Contraceptive Services,[37] Guttmacher Institute. Minor's Access to STI Services,[39] Guttmacher Institute. An Overview of Consent to Reproductive Health Services by Young People, Guttmacher Institute. Minor's Access to Prenatal Care.[38] Additional resources on minor consent laws by state:
English, Abigail. Consent Laws: A Summary, third Edition,[13] School House Connection. Minor Consent for Routine Medical Care,[40] National District Attorneys Association. Minor Consent to Medical Treatment Laws.[36]

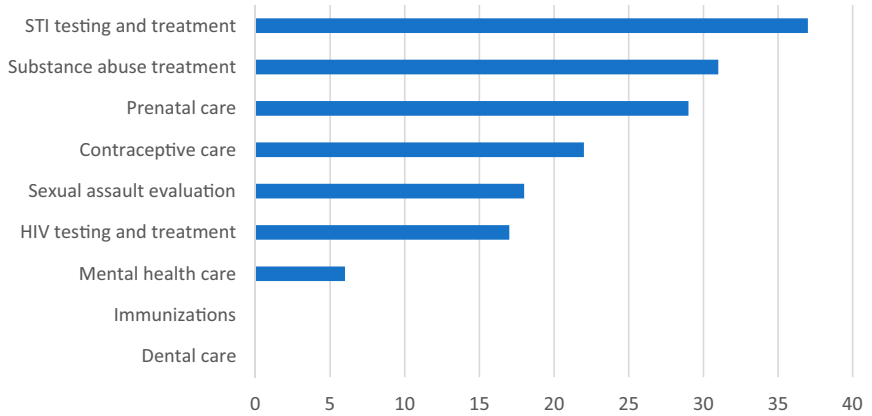

FIGURE 1
Health service types and numbers of states explicitly permitting universal minor consent to each.

prenatal care, 19 for substance abuse treatment, and 9 for mental health treatment.

DISCUSSION

As Table 1 demonstrates, there is substantial variability in state privacy and consent laws that govern adolescent healthcare. This variability prevents guidance on consistent high-quality adolescent health care that abides by all state consent laws and regulations. While sensitive healthcare services can generally be consented to by minors, there is variability in the details of these policies that precludes standardization of guidance. This has ramifications on the provision of care that is consistent and confidential for adolescent patients who are known to be at high-risk for sensitive medical issues. Health care that is provided in states with more restrictive consent and privacy policies may not be consistent with clinically acceptable health care standards.

State policies may differ on the ability to share sensitive health information with the parent or guardian. This creates a scenario in which an adolescent patient may consent to private, confidential care in 1 state and then cross state lines and find that this information is no longer confidential and may be shared with the parent. Inconsistency in privacy protection creates inequitable care and could result in breaches of privacy that place the patient in potentially unsafe situations. We have developed a use case to illustrate the challenges inherent in providing clinical care in the context of varying state laws and regulations (see Use Case below).

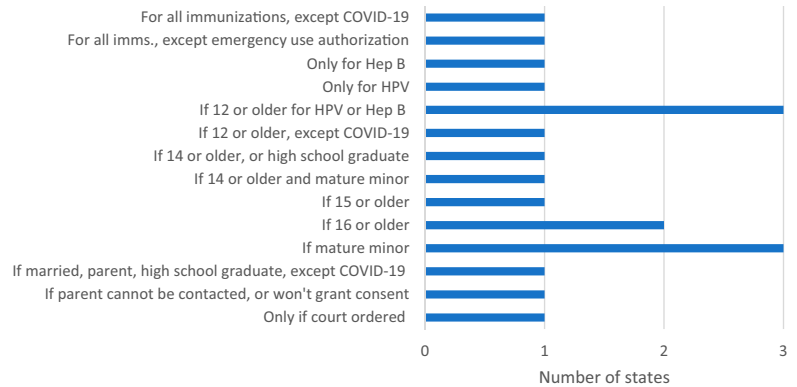

FIGURE 2
Minor consent policies for immunizations (only states with vaccination consent policies included). Hep B, hepatitis B; HPV, human papilloma virus; COVID-19, coronavirus disease 2019. San Francisco minors may consent for COVID-19; Philadelphia minors 11 and older, and able to consent, may consent for COVID-19. Data obtained from state laws listed in Table 2 and the following sources: VAXTEEN, Consent Laws by State 42, Kaiser Family Foundation, State Parental Consent Laws for COVID-19 Vaccination 43. *The information in this table may not be the most updated, accurate or complete.

USE CASE

Diana is 15 years old and identifies as female. Her parents are divorced; she lives with her mother and visits her father, who has a history of domestic violence. Diana has recently become sexually active. In her home state, she may consent to confidential contraceptive care and has a pediatrician who has prescribed oral contraceptive pills (OCPs).

While visiting her father in a different state, Diana develops painful urination and realizes she has forgotten her OCPs. She tells her father she doesn't feel well, and he takes her to the local clinic. Through an application programming interface, the electronic health information is now shared with the new EHR, including information about her OCPs. Since the laws of this state allow health care providers to disclose information to parents, the pediatrician may inform Diana's father of her OCP use. However, the pediatrician chooses not to share this information at this time.

Diana privately discloses her symptoms and the need to refill her OCPs. The pediatrician informs Diana that she can consent to testing and treatment of an STI; however, she would need to go to a federally funded Title X clinic to consent for confidential contraceptive care. Diana is afraid to tell her father this, so she decides to forego the OCP refill, and

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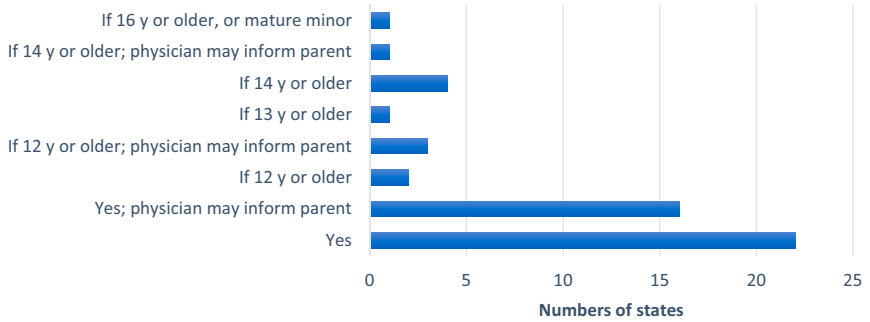

FIGURE 3
Minor consent policy constraints for STI testing and treatment.

consents to STI testing, which comes back positive.

Information about Diana's OCP use is now accessible in her patient portal. Through a proxy account, Diana's father learns about Diana's OCP use and new STI medication. Information about laboratory testing is also included in the after-visit summary and the billing explanation of benefits. Diana's father becomes very angry, and Diana is now fearful for her safety.

As seen in this use case, despite the pediatrician's efforts to protect Diana's privacy, the electronic information exchange system included privacy pitfalls. Differing state laws can create confusion for the patient, her family, the health care provider, EHR developers, and the medical center policy makers. Variability in privacy laws creates challenges in developing EHR systems and electronic health information (EHI) exchange that promotes the exchange of information while maintaining a priority on protecting privacy.

Complexities in the interactions among differing state laws, the Health Insurance Portability and Accountability Act (HIPAA) regulations, and the 21st Century Cures Act can provide conflicting oversight, resulting in inconsistencies in care.[9,13,44–47] Without clear guidance, there are compliance challenges for pediatric health care providers, EHR developers, and medical center policymakers. Increased interoperability and exchange of health information in the setting of state-by-state variability in laws creates challenges in sharing protected health information in a way that remains legally compliant. This creates a major gap in the ability to scale EHI and data exchange in a meaningful way. Since the health system is still limited by EHR technological capabilities and reliable granular filters, it can be difficult to comply with regulations while avoiding breaches of privacy. Furthermore, complexities in interpretation of conflicting regulations, challenges in legal and ethical compliance, and limited resources to navigate state-by-state variability can translate into limitations in access for patients to their health data. Medical centers that lack the bandwidth to adequately address these issues may simply block access as a necessary alternative.

The HIPAA Privacy Rule creates rights for individuals to access their own personal health information and to control access to that information. When a minor has consented to medical care, the parent does not necessarily have the right to access the personal health information related to that care. However, as we have demonstrated, some state laws permit or require disclosure of personal health information of an adolescent to a parent or guardian.[13,44,45] This contradiction could lead to difficulties for providers who need to abide by state laws, even when personal health information is sensitive, and its disclosure could be emotionally upsetting or result in a risk to personal safety.

The 21st Century Cures Act has catalyzed research such as this. With this act, patients and their caregivers now have unprecedented access to EHI. However, variations in state laws may influence how successful the Cures Act is on reducing information blocking among adolescent patients and operationalizing a consistent and equitable care experience. Gaining access to health information empowers adolescent patients and improves patient care; however, harmful consequences can arise when parents or guardians inappropriately access certain personal health information.[48] Appropriate implementation of the privacy exceptions in the Final Rule requires an understanding of the state and federal protection rights of the adolescents within the EHR.[49] Faced with conflicting laws, health care organizations may choose to take no action, which is likely not supportive of high quality care that ensures privacy protection.

The AAP has recommended adolescent confidentiality protections through its evidence-based guidance. According to AAP policy, "Patient-provider confidentiality related to (sensitive) care is a delicate issue, especially when supporting parental involvement. If an adolescent patient is entitled to confidential care, a health care professional generally needs the adolescent's permission to discuss

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her case with her parents." According to the *AAP Red Book*, "Although parental involvement in adolescent health care is always desirable, consent of the adolescent should be sufficient to provide testing and treatment for HIV infection or STIs."[31–33] The AAP's commitment to protecting privacy is further demonstrated in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,[33] which states that pediatricians should "receive training on how to maintain the clinical setting as a 'safe space,' particularly in terms of confidentiality."[33] This resource defines adolescence as 11 to 21 years of age and recommends that these patients be screened for STIs, making "every effort to preserve confidentiality of the adolescent."

However, expert guidance by medical societies is bound by compliance with laws and regulations. *Bright Futures* specifies that, "Pediatricians should consult their own state laws for further guidance, should be aware of their state and local laws, community standards, and public health regulations, and should make use of free and confidential community-based testing programs if there are cost or confidentiality concerns."[32,43]

Medical consensus and clinical research demonstrate what the best, most health-oriented care should look like, but clinicians are potentially put into situations where laws they must abide by are in direct conflict with what is best for patients. Best practices have been established; however, state laws do not necessarily adhere to these standards. Currently, academic society guidelines refer to state laws on consent and confidentiality to maintain legal compliance. The AAP has been deliberately nonprescriptive to avoid situations where its recommendations are in direct conflict with state laws. This limits the ability to construct granular guidance that supports consistent pediatric care nationally in the context of wide-ranging state laws.

Health care providers should be able to provide guidance on how to ensure safe, secure care for all of our adolescent patients.[33] According to the AAP endorsed position paper from the North American Society for Pediatric and Adolescent Gynecology and the Society for Adolescent Health and Medicine,[49] there are multiple steps to protecting adolescent privacy in the setting of the Cures Act Final Rule. These include learning about state and federal laws, meeting with informatics team and legal counsel, and advocating for information access that incorporates adolescent privacy protections.[16,48,49] Even with these efforts and sufficient resources, challenges in aligning the intent of state laws, federal laws, HIPAA regulations, and the 21st Century Cures Act remain.

This is a call to action to address this systemic policy issue in which state laws need to be aligned with best policies and brought closer in line with recommendations for best care. A nationwide effort to harmonize state laws would increase consistency in privacy protection for adolescents. We can't solve these inconsistencies state by state. We must band together, determine the best policies, and promote them for the best interests of our patients.

Limitations

The scope of this paper is limited to a cursory exploration into state laws. This study did not conduct a deep dive into the legal interpretations for each state but was instead an exercise meant to highlight the variability of consent and confidentiality policies inherent in state laws. Complexities in interpretation of the details of state regulations created challenges in developing a concise summary of privacy policies and may have resulted in inconsistencies in interpretations. It is possible that more recent updates in policies may have been missed.

CONCLUSIONS

State-to-state variability of adolescent privacy laws creates challenges for pediatric providers, EHR vendors, and policy makers, particularly in the setting of increased health information exchange. The complex interaction of differing state laws, HIPAA rules, and the 21st Century Cures Act Final Rule creates a challenging setting within which to provide safe, secure medical care for adolescents that complies with best-practice standards. Medical societies have established best practices for adolescent care through research and medical consensus; however, providers must yield to legal compliance with varying state laws. Health care providers, instead of policy makers and politicians, should be the ones determining privacy and confidentiality regulations for adolescent patients.

ABBREVIATIONS

AAP: American Academy of Pediatrics
EHI: electronic health information
HER: electronic health record
HIPAA: Health Insurance Portability and Accountability Act
HIV: Human Immunodeficiency Virus
STI: sexually transmitted infection

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REFERENCES

1. Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE Jr. Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care. A randomized controlled trial. *JAMA*. 1997;278(12):1029–1034
2. Ginsburg KR, Slap GB, Cnaan A, Forke CM, Balsley CM, Rouselle DM. Adolescents' perceptions of factors affecting their decisions to seek health care. *JAMA*. 1995;273(24):1913–1918
3. Jones RK, Purcell A, Singh S, Finer LB. Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception. *JAMA*. 2005;293(3):340–348
4. Lindberg C, Lewis-Spruill C, Crownover R. Barriers to sexual and reproductive health care: urban male adolescents speak out. *Issues Compr Pediatr Nurs*. 2006;29(2):73–88
5. Lothen-Kline C, Howard DE, Hamburger EK, Worrell KD, Boekeloo BO. Truth and consequences: ethics, confidentiality, and disclosure in adolescent longitudinal prevention research. *J Adolesc Health*. 2003;33(5):385–394
6. Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA*. 2002;288(6):710–714
7. Cheng TL, Savageau JA, Sattler AL, DeWitt TG. Confidentiality in health care. A survey of knowledge, perceptions, and attitudes among high school students. *JAMA*. 1993;269(11):1404–1407
8. Lehrer JA, Pantell R, Tebb K, Shafer M-A. Forgone health care among U.S. adolescents: associations between risk characteristics and confidentiality concern. *J Adolesc Health*. 2007;40(3):218–226
9. Vukadinovich DM. Minors' rights to consent to treatment: navigating the complexity of State laws. *J Health Law*. 2004;37(4):667–691
10. Sharko M, Wilcox L, Hong MK, Ancker JS. Variability in adolescent portal privacy features: how the unique privacy needs of the adolescent patient create a complex decision-making process. *J Am Med Inform Assoc*. 2018;25(8):1008–1017
11. Guttmacher Institute. An overview of minors' consent law. Available at: https://www.guttmacher.org/print/state-policy/explore/overview-minors-consent-law. 2017. Accessed October, 2017
12. Maslyanskaya S, Alderman EM. Confidentiality and consent in the care of the adolescent patient. *Pediatr Rev*. 2019;40(10):508–516
13. English A, Bass L, Boyle A, Eshragh F. *State Minor Consent Laws: A Summary*, 3rd ed. Chapel Hill, NC: Center for Adolescent Health & the Law; 2010
14. Weisleder P. Inconsistency among American states on the age at which minors can consent to substance abuse treatment. *J Am Acad Psychiatry Law*. 2007;35(3):317–322
15. Delbanco T, Walker J, Bell SK, et al. Inviting patients to read their doctors' notes: a quasi-experimental study and a look ahead. *Ann Intern Med*. 2012;157(7):461–470
16. Federal Register. 21st Century Cures Act: interoperability, information blocking, and the ONC health IT Certification Program. Available at: https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification#h-141. Accessed June 1, 2021
17. American Academy of Pediatrics. What Pediatricians Need to Know About the 21st Century Cures Act Interoperability Final Rule. Available at: https://www.aap.org/en/practice-management/health-information-technology/what-pediatricians-need-to-know-about-the-21st-century-cures-act-interoperability-final-rule/. Accessed September 23, 2021
18. Bourgeois FC, DesRoches CM, Bell SK. Ethical challenges raised by open notes for pediatric and adolescent patients. *Pediatrics*. 2018;141(6):e20172745
19. Riley M, Ahmed S, Reed BD, Quint EH. Physician knowledge and attitudes around confidential care for minor patients. *J Pediatr Adolesc Gynecol*. 2015;28(4):234–239
20. Bayer R, Santelli J, Klitzman R. New challenges for electronic health records: confidentiality and access to sensitive health information about parents and adolescents. *JAMA*. 2015;313(1):29–30
21. Parsons CR, Hron JD, Bourgeois FC. Preserving privacy for pediatric patients and families: use of confidential note types in pediatric ambulatory care. *J Am Med Inform Assoc*. 2020;27(11):1705–1710
22. Society for Adolescent Health and Medicine; American Academy of Pediatrics. Confidentiality protections for adolescents and young adults in the health care billing and insurance claims

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process. *J Adolesc Health*. 2016;58(3):374–377

23. Spooner SA; Council on Clinical Information Technology, American Academy of Pediatrics. Special requirements of electronic health record systems in pediatrics. *Pediatrics*. 2007;119(3):631–637
24. Bourgeois FC, Taylor PL, Emans SJ, Nigrin DJ, Mandl KD. Whose personal control? Creating private, personally controlled health records for pediatric and adolescent patients. *J Am Med Inform Assoc*. 2008;15(6):737–743
25. Bearinger LH, Sieving RE, Ferguson J, Sharma V. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *Lancet*. 2007;369(9568): 1220–1231
26. Morris JL, Rushwan H. Adolescent sexual and reproductive health: The global challenges. *Int J Gynaecol Obstet*. 2015;131(suppl 1):S40–S42
27. Underwood JM, Brener N, Thornton J, et al. Overview and methods for the Youth Risk Behavior Surveillance System - United States, 2019. *MMWR Suppl*. 2020;69(1):1–10
28. Centers for Disease Control and Prevention. Youth Risk Behavior Survey Data. Available at: www.cdc.gov/yrbs. Accessed April 5, 2021
29. Alderman EM, Breuner CC; Committee on Adolescence. Unique needs of the adolescent. *Pediatrics*. 2019;144(6): e20193150
30. Webber EC, Brick D, Scibilia JP, Dehnel P; Council on Clinical Information Technology; Committee on Medical Liability and Risk Management; Section on Telehealth Care. Electronic communication of the health record and information with pediatric patients and their guardians. *Pediatrics*. 2019;144(1):e20191359
31. Committee on Adolescence; Society for Adolescent Health and Medicine. Screening for nonviral sexually transmitted infections in adolescents and young adults. *Pediatrics*. 2014;134(1): e302–e311
32. American Academy of Pediatrics. *Red Book: 2021-2024 Report of the Committee on Infectious Diseases*. American Academy of Pediatrics; 2021.
33. Hagan JFSJ, Duncan PM. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th edition ed: American Academy of Pediatrics; 2017.
34. Crawford-Jakubiak JE, Alderman EM, Leventhal JM. Crawford-Jakubiak JE, Alderman EM, Leventhal JM, AAP Committee on Child Abuse and Neglect, AAP Committee on Adolescence. Care of the adolescent after an acute sexual assault. *Pediatrics*. 2017;139(3):e20164243. *Pediatrics*. 2017;139(6):e20170958
35. Marcell AV, Burstein GR; Committee on Adolescence. Sexual and reproductive health care services in the pediatric setting. *Pediatrics*. 2017;140(5): e20172858
36. National District Attorneys Association. Minor consent to medical treatment laws. Available at: https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf. Accessed June 6, 2021
37. Guttmacher Institute. Minor's access to contraceptive services. Available at: https://www.guttmacher.org/state-policy/explore/minors-access-sti-services. Accessed June 1, 2021
38. Guttmacher Institute. Minor's access to prenatal care. Available at: https://www.guttmacher.org/state-policy/explore/minors-access-prenatal-care. Accessed June 1, 2021
39. Guttmacher Institute. Minors' to ST I services. Available at: https://www.guttmacher.org/print/state-policy/explore/minors-access-sti-services. Accessed October 1, 2021
40. School House Connection. Minor consent to routine medical care. Available at: https://schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care/. Accessed June 25, 2021
41. VAXTEEN. Consent laws by state. Available at: https://www.vaxteen.org/about. Accessed June 25, 2021
42. Kaiser Family Foundation. State parental consent laws for COVID-19 vaccination. Available at: https://www.kff.org/other/state-indicator/state-parental-consent-laws-for-covid-19-vaccination/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed June 25, 2021
43. Emmanuel PJ, Martinez J; Committee on Pediatric AIDS. Adolescents and HIV infection: the pediatrician's role in promoting routine testing. *Pediatrics*. 2011;128(5):1023–1029
44. English A. Sexual and reproductive health care for adolescents: legal rights and policy challenges. *Adolesc Med State Art Rev*. 2007;18(3): 571–581, viii–ix
45. English A, Ford CA. The HIPAA privacy rule and adolescents: legal questions and clinical challenges. *Perspect Sex Reprod Health*. 2004;36(2):80–86
46. English A, Simmons PS. Legal issues in reproductive health care for adolescents. *Adolesc Med*. 1999;10(2):181–194, v
47. Ford C, English A, Sigman G. Confidential health care for adolescents: position paper for the society for adolescent medicine. *J Adolesc Health*. 2004;35(2):160–167
48. Pageler NM, Webber EC, Lund DP. Implications of the 21st Century Cures Act in pediatrics. *Pediatrics*. 2021;147(3):e2020034199
49. Carlson J, Goldstein R, Hoover K, Tyson N. NASPAG/SAHM statement: The 21st Century Cures Act and adolescent confidentiality. *J Adolesc Health*. 2021;68(2):426–428

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