The Support Center
for School-Based and
School-Linked Health Care

A Guide to School-Based and School-Linked Health Centers

VOLUME V:

Introduction to Legal Issues

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Introduction to Legal Issues

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Advocates for Youth is a nonprofit organization that works to increase the opportunities for and abilities of youth to make healthy decisions about sexuality. Since 1980, Advocates has provided information, education, and advocacy to youth-serving agencies and professionals, policy makers, and the media.

Support Center for School-Based and School-Linked Health Care
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The Support Center, a project of Advocates for Youth, provides information, technical assistance, training, policy analysis, and advocacy to assist in establishing and enhancing school-based and school-linked health centers.

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Acknowledgments

Advocates for Youth thanks the Carnegie Corporation of New York, the W.K. Kellogg Foundation, and the Brush Foundation for supporting the development of this volume of the Guide to School-Based and School-Linked Health Centers.

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INTRODUCTION

Through its extensive work with School-Based and School-Linked Health Centers (SBHC/SLHCs), Advocates for Youth has learned that legal issues are of great concern. Some of the questions most often asked include:

- What should our consent form contain?
- When may adolescents give their own consent?
- What are parents' rights to see their children's records?
- When does a SBHC/SLHC have to notify parents about services provided?
- If a legal problem results from the operation of the health center, who, if anyone, would be liable — the SBHC/SLHC, the sponsoring agency, or the school?
- Which law — federal, state, or local — controls SBHC/SLHC practice?
- What are the restrictions imposed by the various funding statutes and which one supersedes the others if there is a conflict?

The answers to these questions are not simple. The law governing SBHC/SLHC practice is a patchwork of federal, state, and local statutes, regulations, court decisions, and constitutional provisions. Making sense of the myriad laws is a difficult task, even for local attorneys advising a center. In response to these concerns, Advocates for Youth has prepared this Introduction to Legal Issues.

This document presents the legal issues that most concern SBHCs/SLHCs—namely consent, confidentiality, liability, and funding—in a format that is accessible to non-lawyers, but is also helpful for lawyers as they begin researching these topics. This document defines the legal terminology and introduces examples of federal and state statutes controlling the various aspects of SBHC/SLHC practice. It also discusses the rationale behind these laws, and what this legal reasoning means for a center. This document focuses on the concerns most frequently expressed by SBHC/SLHC staff and advocates.

One thing to stress at the outset, and which will be repeated throughout this document, is that this publication is NOT a substitute for consulting with a local attorney who is licensed to practice in the state where the SBHC/SLHC is located. This is an introduction for staff, advocates, and other readers to the law governing SBHC/SLHC practice with examples and discussion that non-lawyers can understand. Once SBHC/SLHC staff and advocates are familiar with the legal framework, they will be better prepared to consult with local attorneys and officials.

CHAPTER ONE:
OVERVIEW OF LEGAL ISSUES FOR SBHC/SLHCS

A. Consent

Consent is an important issue for SBHC/SLHC staff, advocates, clients, and parents. May a minor client consent to health care, or must a center obtain the consent of a parent or guardian? If parental consent is required for general use of a health center's services, are there particular health services to which the minor may consent (e.g., family planning, drug and alcohol abuse, or mental health services)?

This guide begins with a discussion of the theories of patient consent in general, and informed consent in particular. Next, it describes the doctrine and rationale for the requirement of parental consent. It then presents situations where parental consent is not required or where alternatives to parental consent may be used. It also outlines the circumstances in which a minor may give her/his own consent for health care. Finally, it introduces samples of SBHC/SLHC consent forms, as well as a general discussion of the types of consent forms used at some SBHC/SLHCs.

B. Confidentiality

For SBHC/SLHC staff, school personnel, parents, and students, the issue of confidentiality includes numerous questions about access to health center records and information. Do school principals, school districts, or other school employees have legal access to the center's records and to confidential information about the care students receive? What about a student and the student's parents or guardian? Few statutes or cases directly address when parents have access to confidential information about their minor children's health care; fewer, if any, do so in the context of SBHC/SLHC practice. There is, however, a body of law to guide SBHC/SLHCs.

Confidentiality requirements for health care providers begin with a discussion of federal privacy and confidentiality protections. Next are examples of state statutes which protect the confidentiality of medical information, including medical records, as well as state statutes which address parental notification requirements and parental access to confidential information concerning health care for their minor children. A discussion of the different ways in which the federal and state law treats school records and health records is also important.

C. Liability

SBHC/SLHC workers and advocates, as well as school administrators, are troubled by liability issues. The mere mention of the word evokes images of huge damage awards from juries and the corresponding increase in insurance premiums. The fear of legal liability often is one of the greatest obstacles to establishing an SBHC/SLHC in the first place. Despite these legitimate apprehensions, the Support Center is unaware of any successful legal claim brought

against an SBHC/SLHC. Nevertheless, it is important for center staff and advocates to understand liability issues.

Despite the widespread apprehension over liability, it seems that few people understand exactly what liability means. The discussion of the basic types of legal liability addresses questions regarding who may be held liable and for what. It also examines which legal authority applies to disputes over liability — federal, state, or local law.

D. Funding

The issue of funding for SBHC/SLHCs involves consent, confidentiality, and liability questions. Both federal and state statutes which provide funding, directly or indirectly, for SBHC/SLHCs put restrictions on the use of funds. These restrictions include consent requirements for services and confidentiality mandates, which, in the case of federal funding statutes, may supersede state law. Both federal and state statutes may also specify liability for violations and the penalties for violations of statutes.

Chapter Six provides examples of both federal and state funding statutes, beginning with a general discussion of federal programs which have funded SBHC/SLHC programs and some of their restrictions, and following with examples of state funding statutes for SBHC/SLHCs and similar adolescent health programs, all with a focus on the requirements or restrictions imposed through state funding statutes.

CHAPTER TWO:

CONSENT

In general, the law places the authority for health care decisions with the patient in order to protect the individual's autonomy and control over her/his body. Thus, a health care provider must obtain the patient's informed consent before performing a test, operation, procedure, or treatment. The legal standard for informed consent is whether the physician has given the amount of information a patient has a right to expect prior to making an informed choice about the proposed procedure or treatment and whether the patient has made a voluntary choice among the alternatives. The law, therefore, imposes upon the physician a duty to warn the patient of risks and possible outcomes.[1] If the doctor fails to obtain the patient's informed consent, the physician may be found liable for damages for negligence. Informed consent is considered so fundamental to medical practice that the American Medical Association's First, Second, and Fifth Principles of Medical Ethics address the ethics of informed consent.[2]

As is often the case, however, what constitutes informed consent is a matter of interpretation: exactly how much information must the patient be given for consent to be "informed"? A general definition for informed consent would be consent given knowingly (the patient understands the risks of and alternatives to a treatment), competently (the patient is able to give consent mentally, e.g., the patient is not too young or mentally incapacitated to give consent), and voluntarily (the patient has not been coerced into giving consent).[3]

A. Parental Consent for the Treatment of Minors

Until the mid-20th Century, minors were considered incompetent as a matter of law to enter into binding legal contracts, including contracts with physicians, or to give informed consent to medical care. Thus, parental consent for health care traditionally has been required. The general rule is that a physician must obtain the informed consent of a parent or guardian before the physician can treat a minor (usually defined by the state as a person under 18 years of age).[4]

A number of rationales support this legal rule. First, minors are generally thought to lack the capacity to make their own medical decisions and must be protected from their own mistakes.[5] Based on the assumption that minors need to be protected from their mistakes in medical decision making, the law authorizes parents to give consent because parents are considered to possess the intelligence, maturity, and experience needed to make these important decisions, and are believed to have the same interest as the minor in the young person's health.[6] Unfortunately, this is not always true, particularly in the case of child abuse or neglect, as discussed below.

A second rationale for requiring parental consent is that it promotes both the state's and the family's interest in encouraging parental participation in minors' lives.[7] Promoting family autonomy and parental control are thought to strengthen the family as an institution.

Finally, the health care provider's interest in payment for services also is reflected in the parental consent requirement.[8] Parents are financially responsible for services provided to their minor children and most minors lack the financial resources to pay for medical care. In view of their financial responsibility, parents have an interest in determining whether or not the minor receives treatment, and which treatment should be given.

The parental consent requirement, however, has been modified considerably over the past several decades. The law now recognizes that minors are often competent to understand the implications of medical decisions and are frequently reluctant to seek treatment for "sensitive" issues if they are required to involve their parents. The evolution of the law has resulted in a number of important alternatives and exceptions to the requirement of parental consent for medical treatment.

B. When Parental Consent is Not Required: Emergencies

A health emergency is "a condition requiring immediate treatment to protect the patient's life or health."[9] In a health emergency, a physician or other health care provider may treat a minor without parental consent. The rationale behind this exception is obvious: in an emergency, time is critical and life or health could be endangered if prompt medical attention is not given. Taking the time to obtain a parent or guardian's consent could well jeopardize the minor's life or health. A number of state legislatures have codified the medical emergency exception,[10] but it is accepted throughout the United States.

C. Alternatives to Parental Consent

In a number of situations the consent of someone other than a parent is either required or is considered legally sufficient for the treatment of a minor patient. A notable example is when the state is acting in the role of a parent or guardian for the minor, such as when the minor is under the jurisdiction of the juvenile courts or is in the care of a child welfare agency. In these situations state law usually authorizes the juvenile court or the child welfare agency to authorize medical care.[11] The rationale for these situations is that when the care for a minor has been taken over by the state due to the neglect, failure, or absence of a parent, the state is acting as a substitute for the parent in caring for the minor.

D. When Minors May Consent

A health care provider must obtain a patient's informed consent before providing medical care.[12] In general, a physician must obtain that consent from a parent or guardian for the care of a minor.[13] As noted above, however, there are a number of exceptions to this rule. The first exception is when an adolescent reaches the age of majority, usually age 18 years (see Table I). Additional exceptions are described below.

1. Exceptions based on the minor's status

Numerous exceptions to the requirement of parental consent are based on the minor's status. For example, one or more states has laws which allow each of the following groups of minors to give their own consent for care:

- emancipated minors
- mature minors
- married minors
- minor parents
- pregnant minors
- minors who are serving in the military
- minors who are living apart from their parents, including runaway and homeless youth
- high school graduates
- minors who have reached a specific age.[14]

While few, if any, states have adopted all of the above, some of the categories, such as the emancipated minor or mature minor, have broad general applicability even in the absence of a specific state statute.

The emancipated minor

A number of state legislatures have recognized that there are cases in which a minor is sufficiently independent to be legally free of her/his parents' control and to make many decisions, including medical decisions, on the same basis as adults. In legal terms, such a minor is "emancipated." Historically, minors were considered legally emancipated if they were married, serving in the military, or living apart from their parents and financially independent.[15] More recently, some states have enacted statutes to recognize that a minor is emancipated if s/he is in the military[16], or is married[17], and in many states, once a minor reaches a certain age and meets specified criteria, a court may certify that s/he is emancipated as a matter of law.[18] The factors which will persuade a court to declare a minor emancipated include whether the minor lives independently of her/his parents, supports her/himself financially, and is in charge of her/his own affairs. Emancipated minors are treated as adults for most purposes and, as such, are usually permitted to consent to medical treatment.[19]

A SBHC/SLHC treating an emancipated minor faces fewer restrictions on the care and services it may provide without the consent of a parent or guardian, because for most purposes an emancipated minor is legally the equivalent of an adult. SBHC/SLHCs should therefore consider including a question on consent forms to determine whether an individual is emancipated by court order, married, or in the military (if applicable in the health center's state).

The mature minor

Another exception to the parental consent requirement which has broad applicability is the "mature minor" doctrine. As previously discussed, the parental consent requirement is based, in part, on the assumption that minors lack the requisite knowledge and sophistication to make informed choices about their medical care.[20] Recently, some courts and state legislatures[21] have acknowledged that some minors have the capacity (i.e., are mature enough) to make informed

medical decisions and, therefore, to consent for medical care. One state court defined maturity as "hav[ing] the intellectual capacity, experience, and knowledge necessary to substantially understand the situation at hand and the consequences of the choices that can be made."[22] To qualify under the mature minor doctrine, a minor does not need to receive a formal judicial declaration in advance.

Since the mature minor exception is primarily recognized by state courts,[23] SBHC/SLHCs should consult legal counsel to determine whether the exception applies in the local jurisdiction. If the exception is available, either by statute or court decision, SBHC/SLHC staff should be familiar with factors the state court or legislature considers to determine maturity or to which services a mature minor may consent. According to some experts, a SBHC/SLHC may accept the consent of a "mature minor" where:

- The minor is 15 years of age or older.
- The minor is able to give informed consent: in the judgement of the health care provider, the minor is of sufficient maturity and intelligence to understand and appreciate the benefits and risks of the proposed treatment and to make a reasoned decision based on this knowledge.
- The proposed treatment is for the minor's benefit and not for the benefit of another.
- The proposed treatment is deemed necessary according to the best professional judgement.
- The treatment does not involve complex, high-risk medical procedures or complex, high-risk surgery.[24]

Since the mature minor doctrine has largely evolved from court decisions, a SBHC/SLHC should be cautious if it chooses to rely on the doctrine to allow minors to consent for care. The center should develop a policy regarding the mature minor doctrine in consultation with legal counsel.

2. Exceptions for specific health services

The remaining exceptions to the parental consent requirement are based on specific types of health care services. Some or all states have laws which permit minors to consent for one or more of the following services:

- pregnancy related care
- contraceptive services
- abortion
- diagnosis and treatment of sexually transmitted disease
- HIV testing or treatment
- diagnosis and treatment of reportable infectious, contagious, or communicable disease
- treatment of drug or alcohol problems
- diagnosis or treatment for sexual assault
- outpatient or inpatient mental health counseling.[25]

Some of these exceptions, and their justifications, are discussed below. A chart prepared by the Alan Guttmacher Institute (AGI) listing the parental consent

requirements for certain specific health care services is included in Table I. This chart is a useful reference for the consent requirements in a particular jurisdiction, although the information must be verified to ensure that it is current and comprehensive. This chart, however, is not a substitute for qualified legal counsel in the formulation of a legal consent form or other procedures related to consent.

Exceptions for pregnancy-related services

Exceptions to the parental consent requirement for provision of contraceptive services to minors are based not only on the specific statutes enacted by many states but also on federal law, specifically the United States Constitution, as interpreted by the Supreme Court. In 1965, the United States Supreme Court held, in Griswold v. Connecticut, that the Constitution includes a right to privacy, which protects the right of married couples to use contraception.[26] In subsequent decisions, the Court extended the right of privacy to include an unmarried person's access to contraception,[27] minors' access to contraception,[28] adult women's access to abortion,[29] and minors' access to abortion.[30] In each of these cases, the common thread in the Court's decision was that the Fourteenth Amendment included some protection for individual "liberty" or "personal autonomy."

In the case of minors' access to both contraception and abortion, the Supreme Court includes the parents' interests in its analysis of the exercise of a fundamental right. According to the Court, the "guiding role of parents in the upbringing of children" justifies placing limits on the freedom of minors.[31] Thus, while the Fourteenth Amendment and the Bill of Rights do not apply to adults alone,[32] the state may limit the freedom of minors in making important choices that have potentially serious consequences. The Court justifies this limitation on a minor's freedom based on the notion that minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them.[33]

Contraceptive Services

In addition to the court decisions that address minors' access to contraceptive services, many states have enacted specific statutes allowing minors to obtain these services based on their own consent.[34] These states are listed in Table I.

The provision of contraceptive services to minors is a controversial issue, and one the courts have grappled with on numerous occasions. The controversy may affect SBHC/SLHCs with respect to the issue of federal funding for contraceptive services. Federal courts have held that a state may not impose a parental consent requirement for provision of contraceptive services to minors that are funded by Medicaid[35] or the Title X Family Planning program.[36] SBHC/SLHCs that accept Medicaid or Title X funding may face some conflicts with state parental consent requirements for contraceptive services. Once again, the SBHC/SLHC should work with an attorney to ensure compliance with applicable laws and to resolve any conflicts between these laws.

Abortion

A number of cases address the issue of parental consent or notification and minors' access to abortion. This discussion is included here in the interest of full treatment of the question of when minors may consent to medical treatment. Since no SBHC/SLHC currently performs abortions, however, the following discussion is not directly applicable to SBHC/SLHC practice.

Under the Supreme Court's decisions, states may require parental consent for minors to obtain an abortion, provided there is a mechanism for minors to secure authorization from a court or other state entity in lieu of obtaining parental consent.[37] The federal Constitution therefore requires that states which mandate parental consent for a minor to obtain an abortion must have a "bypass" procedure, whereby the young woman can petition a court for permission to procure the abortion without her parent's consent:[38]

> In reviewing an abortion petition, a court must allow a mature minor to make her own decision and must determine whether it is in the best interest of an immature minor to have an abortion without notifying her parents.[39]

A few states, as an alternative to the judicial bypass, have enacted statutes which allow the minor to obtain the consent of an adult relative, another doctor, a religious leader, or other specified adult.[40]

It is also important to note that Supreme Court decisions and other laws distinguish between parental consent restrictions and parental notification restrictions on abortion. The test most recently enunciated by the Court for evaluating restrictions on the right to abortion services is whether a particular state statute places an "undue burden" on the exercise of a woman's fundamental right.[41] Since 1981, the Court has held that some parental notification requirements for minors seeking abortions are constitutional.[42] The Court has struck down a two-parent notification statute,[43] but upheld a parental notification law that provided for a judicial bypass of the notification requirement.[44] The Court has not specifically applied the undue burden test (as announced in the Casey decision) to parental notification laws, but given the Court's prior parental involvement decisions, it appears likely that such a law would be found to be constitutional, provided the statute contains a bypass procedure.

Exceptions for sexually transmitted diseases (STDs) and HIV/AIDS

Minors may receive testing and treatment without parental consent for STDs in almost every state and for HIV/AIDS in some states.[45] The rationale behind these exclusions is that STDs and HIV/AIDS are extremely serious health risks both for the individual and for others in the community. Consequently, early detection, treatment, and counseling for people with STDs are critical. If minors were forced to obtain parental consent before testing or treatment for a possible STD or HIV infection, they might be dissuaded from seeking such care for fear of parental reactions. The health risks are too great to allow anything to thwart the prompt identification and treatment of individuals with STDs or HIV/AIDS.

Alcohol and drug abuse treatment

Almost every state has a law allowing minors to consent to treatment for drug and alcohol abuse, or to receive treatment without parental consent.[46] The reasoning behind this exception is that drug and alcohol abuse are serious concerns for adolescents, and sometimes these problems are linked to minors' relationships with their parents. A parental consent requirement may, therefore, cause some minors to avoid seeking treatment for fear of parental disapproval, or worse.

Outpatient mental health services

A little less than half of the states authorize minors to consent for outpatient mental health services.[47] A few of these statutes contain age restrictions (ranging from ages 12 to 16), but many do not. The justification for this exception is that a minor may be unwilling to reveal a mental health problem to her/his parents, or the mental health issue could be related to parental behavior. Thus a parental consent requirement would deter the minor from seeking treatment.

Table I summarizes the various state parental and minor consent laws for the health services described above. Although Table I does not include all provisions of state law authorizing minors to consent for medical care, it provides an excellent representative overview.

TABLE I **Many states explicitly authorize an unmarried minor to make**

State	Age of Majority	Contraceptive Services	Prenatal Care	STD-HIV/AIDS Services	Treatment for Alcohol and/or Drug Abuse	Outpatient Mental Health Services	General Medical Care
Alabama	19	NL	MC	MC[2,3,4]	MC	MC	MC[5]
Alaska	18	MC	MC	MC	NL	NL	MC[7]
Arizona	18	NL	NL	MC	MC[2]	NL	NL
Arkansas	18	MC	MC[9]	MC	NL	NL	MC[10]
California	18	MC	MC9	MC[2,13]	MC[2,4]	MC[2]	NL
Colorado	18	MC	NL	MC[13]	MC	MC[4,15]	NL
Connecticut	18	NL	NL	MC[13]	MC	MC	NL
Delaware	18	MC[2,4]	MC[2,4,9,10]	MC[2,4,13]	MC[2]	NL	NL
Dist. Columbia	18	MC	MC	MC	MC	MC	NL
Florida	18	MC[18]	MC[10]	MC[3]	MC	MC[19]	NL
Georgia	18	MC	MC[9]	MC[3,4]	MC[4]	NL	NL
Hawaii	18	MC[4,20]	MC[4,9,20]	MC[4,20]	MC[4]	NL	NL
Idaho	18	MC	NL	MC[3,20]	MC	NL	MC
Illinois	18	MC[18]	MC[10]	MC[2,3]	MC[2]	MC[2,4]	MC[10,22]
Indiana	18	NL	NL	MC	MC	NL	NL
Iowa	18	NL	NL	MC[13,24]	MC	NL	NL
Kansas	18	NL	MC[10,25]	MC[4]	MC	NL	MC[6,10,25]
Kentucky	18	MC[4]	MC[4,9]	MC[3,4]	MC[4]	MC[4,6]	MC[4,7,10]
Louisiana	18	NL	NL	MC[4]	MC[4]	NL	MC[4,10]
Maine	18	MC[18]	NL	MC[4]	MC[4]	MC[4]	NL
Maryland	18	MC[4]	MC[4]	MC[4]	MC[4]	MC[4,6]	MC[4,7]
Massachusetts	18	NL	MC[9]	MC	MC[2]	MC[6]	MC[7,10,22]
Michigan	18	NL	MC[4]	MC[4,13]	MC[4]	MC[20]	NL
Minnesota	18	NL	MC[4]	MC[4]	MC[4]	NL	MC[7]
Mississippi	21[31]	MC	MC[10]	MC[3]	MC[4,15]	NL[31]	MC[31]
Missouri	18	NL	MC[4,9,10]	MC[4,10]	MC[4,10]	NL	MC[7,10]
Montana	18	MC[4]	MC[4,10]	MC[4,10,13]	MC[4,10]	MC[6]	MC[4,7,10]
Nebraska	19	NL	NL	MC	MC	NL	NL
Nevada	18	NL	NL	MC[3]	MC	NL	MC
New Hampshire	18	NL	NL	MC[20]	MC[2]	NL	MC
New Jersey	18	NL	MC[4,10]	MC[4,10]	MC[4]	NL	MC[4,7,10,22]
New Mexico	18	MC	NL	MC[13]	MC	MC	NL
New York	18	MC	MC	MC[13]	MC	MC	MC[7]
North Carolina	18	MC	MC[9]	MC[3]	MC	MC	NL
North Dakota	18	NL	NL	MC[20]	MC[20]	NL	NL
Ohio	18	NL	NL	MC[13]	MC	MC[20]	NL
Oklahoma	18	MC[4,35]	MC[4,9]	MC[3,4]	MC[4]	NL	MC[4,7,10]
Oregon	18	MC[4]	NL	MC[3,10]	MC[4,20]	MC[20]	MC[4,10,15]
Pennsylvania	21	NL	MC	MC[3]	MC[4]	NL	MC[35,36]
Rhode Island	18	NL	NL	MC[13]	MC	NL	NL
South Carolina	18	NL[37]	NL[37]	NL[37]	NL[37]	NL[37]	MC[37]
South Dakota	18	NL	NL	MC	MC	NL	NL
Tennessee	18	MC	MC	MC[3]	MC	MC[6]	NL
Texas	18	NL	MC[4,9,10]	MC[3,4,10]	MC[4]	MC	NL
Utah	18	NL	MC	MC	NL	NL	NL
Vermont	18	NL	NL	MC[2,3]	MC[2]	NL	NL
Virginia	18	MC	MC	MC[3]	MC	MC	NL
Washington	18	NL	NL	MC[3,20]	MC[20]	MC[19]	NL
West Virginia	18	NL	NL	MC	MC	NL	NL
Wisconsin	18	NL	NL	MC	MC[2]	NL	NL
Wyoming	18	MC	NL	MC[3]	NL	NL	NL
Total* explicitly allowing minor to consent or decide		24	28	50	46	22	22
Total* specifically requiring parental consent or notice		0	0	0	0	0	0
Total* with no specific law or not applicable		27	23	1	5	29	29

*Includes District of Columbia **NL**-No law found **MC**-Minor authorized to consent or decide **PC**-Parental consent explicitly required

decisions about medical care and other important issues

Abortion Services[1]	Dropping Out of School	Getting Married	Medical Care for Child	Placing Child for Adoption
PC	MC[6]	PC	MC	MC
NL	MC[6]	PC	MC	NL[8]
NL	MC[6]	PC	NL	MC
PN[11]	PC	PC	MC[10]	MC[12]
NL	NA[14]	PC	NL	MC
NL	MC[6]	PC	MC[10]	MC
MC	MC[6]	PC	MC	MC[12]
PN[16]	MC[6]	MC[17]	MC[10]	MC
MC	NA[14]	PC	MC	MC
NL	MC[6]	MC[17]	MC[10]	NL[8]
PN	MC[6]	MC[17]	MC[10]	MC
NL	NA[14]	PC	NL	MC
NL[21]	MC[6]	PC	MC[10]	MC
NL[23]	MC[6]	PC	MC[10]	MC
PC	PC	PC	NL	MC
NL	MC[6]	PC	NL	NL[8]
PN	MC[6]	PC	MC[10]	MC
PC	MC[6,26]	MC[17]	MC[10]	MC[12]
PC	MC[27]	PC	MC	PC[28]
MC[29]	MC[27]	PC	NL	NL[8]
PN[30]	MC[6]	MC[17]	MC	NL[8]
PC[11]	MC[6]	PC	MC	NL[8]
PC	MC[6]	PC	MC[4]	PC
PN[11]	MC[6]	PC	MC	PC
PC[11]	MC[27]	PC	MC	MC
PC	MC[6]	PC	MC[10]	MC
NL	MC[6]	PC	MC[4,10]	MC
PN	MC[6]	MC[27]	NL	NL[8]
NL	MC[27]	PC	MC	MC
NL	PC	PC	NL	MC[32]
NL	MC[6]	PC	MC[10]	MC
NL	MC[6]	PC	NL	MC
NL	MC[6]	PC	MC	MC
PC[33]	MC[27]	PC	NL	MC
PC[11]	MC[6]	PC	NL	NL[8]
PN[34]	NA[14]	PC	NL	MC
NL	PC	MC[17]	MC[10]	MC[6]
NL	PC	PC	NL	NL[8]
PC	MC[27]	PC	MC	PN
PC	MC[6]	PC	MC	PC
PC[33]	MC[27]	PC	MC	MC
NL	MC[6]	PC	NL	NL[8]
PC	MC[27]	PC	NL	MC
NL	MC[27]	MC[38]	NL	NL[8]
PN[11,39]	NA[14]	PC	MC	MC
NL	MC[6]	PC	NL	MC
NL	NA[14]	PC	NL	MC
NL	MC[40]	PC	NL	MC[12]
PN[41]	MC[6]	PC	NL	MC
PC[33]	MC[27]	PC	NL	NL[8]
PC	MC[6]	PC	NL	MC
3	40	8	29	34
26	5	43	0	5
22	6	0	22	12

PN- Parental notice explicitly required **NA**-Not applicable

References

1. Includes only parental consent and notification laws that are currently enforced. These laws include a judicial bypass except where indicated. **2.** Minor must be 12 or older. **3.** State officially classifies HIV/AIDS as an STD or infectious disease, for which minors may consent for testing and treatment. **4.** Doctor may notify parents. **5.** Minor must be 14 or older, a high school graduate, married, pregnant or a parent. **6.** Minor must be 16 or older. **7.** Minor may consent if has a child. **8.** Law does not distinguish between minor and adult parents. **9.** Excludes abortion. **10.** Includes surgery. **11.** Involvement of both parents required in most cases. **12.** Minor parent must have court-appointed guardian. **13.** Law explicitly authorizes minors to consent to HIV testing and/or treatment. **14.** Minor may not drop out before graduation. 15. Minor must be 15 or older. **16.** Notice may be given to grandparent or licensed mental health professional. **17.** A minor who is pregnant or, in DE, FL, GA, MD and OK, has a child may get married without parental consent; in FL, KY and OK, the marriage must be authorized by a court; in MD, a minor must be at least 16. **18.** Minor may consent if has a child or doctor believes minor would suffer "probable" health hazard if services not provided; in FL and IL, also if minor is pregnant; in IL also if referred by doctor, clergyman or Planned Parenthood clinic. **19.** Minor must be at least 13. **20.** Minor must be at least 14. **21.** Law requiring notice of both parents "if possible" without a judicial bypass is not enforced consistently throughout the state. **22.** Minor may consent if pregnant. **23.** June 1995 law requiring notice to parent or grandparent temporarily enjoined pending state supreme court's issuance of rules governing appeals of bypass petitions that are denied. **24.** Parent must be notified if HIV test is positive. **25.** Minor may consent if parent is not "available," or in the case of general medical care, "immediately available." **26.** Parent must be notified. **27.** Minor must be at least 17. **28.** Court may waive parental consent if the minor is "sufficiently mature and well informed" or the adoption is in the child's best interest. **29.** Minor may be counseled by physician or a counselor in lieu of obtaining parental consent or court authorization. **30.** Law has no judicial bypass; however, a physician may waive notification if the minor does not live with a parent; or if a doctor determines that the minor is mature enough to give informed consent or that notification may lead to physical or emotional abuse of the minor or otherwise to be contrary to her best interests; or if reasonable effort to give notice was unsuccessful. **31.** Persons age 18 or older are considered adults for purposes of consenting to medical care; however, any minor who is mature enough to understand the nature and consequences of the proposed medical or surgical treatment may consent. **32.** Court may require consent of a minor parent's parent. **33.** Grandparent or, in WI another adult relative over age 25, may consent instead of parent. **34.** Stepparent, grandparent or sibling over age 21 may be notified if minor files affidavit stating she fears physical, sexual or severe emotional abuse from parent. **35.** Minor may consent if she has ever been pregnant. **36.** Minor may consent if she has graduated from high school. **37.** Any minor 16 and older may consent to any health service other than operations. Health services may be rendered to minors of any age without parental consent when the provider believes services are necessary. **38.** Minors 16-18 may petition court for permission to marry; parents must be notified. **39.** Notification required if possible; law includes no judicial bypass. **40.** Minor may drop out at 15 if employed or is proficient in grades 1-9. **41.** Notice or judicial bypass can be waived if second physician determines that minor is mature enough to give consent or that notice would not be in her best interest.

Alan Guttmacher Institute, Issues in Brief, November 1995

E. Sample Consent Forms

Advocates for Youth maintains files of consent forms used by SBHC/SLHCs from around the country. These forms illustrate the different approaches centers take to adapt their practice to the law. The discussion that follows analyzes the advantages and disadvantages of the varying strategies for dealing with parental consent and treatment of minors in SBHC/SLHCs.

1. Checklist vs. blanket consent forms

SBHC/SLHCs use two basic types of consent forms: a form which lists all available services that are available and seeks "blanket" parental consent to all of those services for the minor (see Appendices A and B); and a form which lists services and provides an opportunity for parents to check off or otherwise designate which services they will allow their minor children to receive (see Appendices C and D). There are both positive and negative implications for each format.

On the one hand, allowing parents to consent to specific services for their minor children reinforces the guiding role of parents in their children's lives—one of the primary justifications for parental consent laws. On the other hand, allowing a parent or guardian to select some services from a list creates administrative problems for the SBHC/SLHC staff. Each time a minor seeks a specific service, the SBHC/SLHC must verify that it has the required parental consent. SBHC/SLHC staff must constantly refer to the consent forms to ensure that they are able to provide a specific service to the individual client. One way to avoid this problem is by grouping services on the form—particularly controversial ones such as contraception—so the parent may provide a blanket consent for groups of services.

The "blanket" consent format avoids the possible administrative difficulties of checklists. While there is a risk that a parent may object to one of the services on the list and withhold consent entirely, in practice this occurs infrequently. The sample forms include examples of ones used in situations in which a minor may legally consent to specific health care services under state law, and where the clinic has chosen to honor that option. In such cases, the consent form should inform both the parent and the minor of their rights.

2. Consent forms and confidentiality

Every consent form should emphasize that confidentiality requirements are applicable to the SBHC/SLHC's records and practice. This statement reassures both the parent or guardian of the minor and the minor patient. Knowing that any information the minor shares with the clinic will be kept confidential encourages minor patients to be forthcoming with the SBHC/SLHC staff, and it assures parents that sensitive information about their children will not be publicly accessible. The confidentiality statement also protects SBHC/SLHC staff by clearly enunciating the health care provider's duty to protect patient confidentiality in cases where others seek access to the client's medical records.

CHAPTER THREE:
CONFIDENTIALITY

In the health care setting, maintaining confidentiality honors the right of people to have their records and information protected from unauthorized disclosure to others. The justification for confidentiality is simple: the information patients share with health care providers is extremely personal and may be embarrassing. Patients, therefore, expect that it will be kept private and, in fact, often will not seek care if they doubt that confidentiality will be maintained. To provide the best treatment, health care providers need to obtain all the relevant facts from their patients. If an individual fears that her/his personal information will be made available to others, s/he may be reluctant to tell the provider all relevant information. In light of these concerns, health care providers have a fiduciary duty (the highest legal degree of obligation or duty) to protect the confidentiality of patients.[48]

Specific aspects of the confidentiality between health service providers and minors and the disclosure of confidential information by providers to parents or others are addressed infrequently in statutes or case law.[49] Nevertheless, information and records pertaining to health care provided to minor patients are, in general, confidential. The most significant questions concern who has the right to authorize disclosure and when may (or must) the information or records be disclosed without prior authorization.

There are some notable exceptions to the confidentiality requirement as it relates to minors and their parents. A few state statutes require that parents be notified of specific treatments or procedures to be performed on minors. Important distinctions also exist between school records (e.g., school nurse's records) and health records (e.g., SBHC/SLHC records). Both federal and state law treat school records differently than medical records. Minors' right of access to school records is not the same as their right of access to their medical records. Similarly, parents' right of access to their minor children's school records is different than their right to see medical records. For SBHC/SLHCs, all of these laws mean varying confidentiality requirements for different types of information or records.

A. Sources of the Confidentiality Requirement

The requirement of confidentiality in health care is found in numerous federal and state sources, including:

- State licensing laws for physicians and other health care providers[50]
- State statutes governing health care information and records[51]
- Federal laws and regulations for confidentiality which apply to organizations that receive federal funds.[52]

1. Federal protection of confidentiality

The Federal Privacy Act

In an attempt to codify a right to privacy for personal records, Congress passed the Federal Privacy Act.[53] According to the Congressional findings accompanying the act, the purpose of the statute was to protect individuals against invasions of their personal privacy.[54] The Privacy Act does not, however, apply to agencies outside of the federal government, or agencies that simply receive federal funds.[55] The Privacy Act states that "no [federal] agency shall disclose any record . . . except pursuant to a written request by, or with the prior written consent of, the individual . . .."[56] In this formulation, Congress recognizes the power the government holds over the individual by maintaining records which may contain extremely personal information, of which unauthorized disclosure would be injurious. Medical records maintained by the government provide a clear example of this.

The Department of Health and Human Services (HHS) has developed regulations, in keeping with the spirit of the Federal Privacy Act, for maintaining the confidentiality of medical records.[57] These regulations set out specific procedures for notification of, or access to, medical records. They apply to federal agencies and to any federally-funded organization that keeps medical records. Information or records may only be released to the individual, or with the written consent of the individual, unless they are subject to a court order.[58]

The HHS regulations also contain special procedures for disclosure of the medical records of minors.[59] A minor is entitled to access her/his medical records through a physician designated by the minor; the records may not, however, be disclosed directly to the minor's parent or guardian.[60] If a parent or guardian requests access to a minor's medical records, the minor must designate a physician to whom the records will be given. The physician then has the discretion as to whether to disclose information to the parent or guardian. Through this procedure, federal agencies and federally-funded organizations are mandated to protect the confidentiality of minors' health records and information.[61]

Federal funding statutes and confidentiality

A number of federal statutes through which SBHC/SLHCs may be funded contain specific confidentiality provisions. For example, both the Title V Maternal and Child Health Services Block Grant Act and the Title X Family Planning program provide that all information gathered through the programs must be held confidential and cannot be released without the consent of the individual.[62]

2. State protection of confidentiality

A variety of state laws protect the confidentiality of medical information and records. These include licensing laws for health care professionals, physician-patient and psychotherapist-patient privileges, medical records statutes, and some of the minor consent statutes.[63]

Statutes concerning medical records and disclosure

Many state laws protect the confidentiality of, and patient access to, medical records.[64] These laws are explicit. A Florida statute, for example, provides: "Patient records are confidential and must not be disclosed without the consent of the person to whom they pertain."[65] As already discussed, these statutes recognize the need for confidentiality between patients and health care providers,

both to protect the individual from harmful or embarrassing disclosure of personal information, and to ensure open and full communication between the provider and client. Approximately 23 states have made willful violation of a confidential communication grounds for revocation of a physician's license.[66] Some states specify that a physician must maintain patient confidentiality as part of the state's licensing requirements.[67]

Minor's medical information and records: confidentiality and parental notification

Confidentiality in health care is more complicated when the treatment of minors is involved. In addition to the interests of the patient and provider, the concerns of the minor's parent or guardian are factored into the relationship. For the same reasons that the law requires parental consent for the treatment of minors—to further the parent's guiding role in light of minors' perceived lack of capacity, to protect family autonomy and family participation, and to recognize the parent's financial responsibility for the minor's treatment—some states provide that the parent or guardian be notified that the minor is seeking or has received medical services.

A number of these parental notification laws give the provider discretion as to whether to inform the parent or guardian about a minor's treatment.[68] A few states, such as Louisiana, allow disclosure without the consent—and over the specific objection of—the minor,[69] or allow notification if the physician believes the minor's life is in danger, even if the minor is married, a parent, pregnant, or otherwise emancipated.[70] Other states provide guidance to providers as to when they may notify the parent or guardian about treatment of the minor, such as in Montana where a parent may be notified if:

(a) severe complications are present or anticipated

(b) major surgery or prolonged hospitalization is needed

(c) failure to inform would seriously jeopardize the health of the minor

(d) the information would benefit the minor's health and family harmony

(e) the [health care provider] desires a third-party commitment to pay for services.[71]

Given the variations in parental notification statutes, SBHC/SLHC staff and advocates must be familiar with the applicable confidentiality and parental notification laws in their jurisdiction to determine which standards apply.

Mandatory disclosure of confidential information

In specific circumstances, a health care provider may be obligated to disclose otherwise confidential information. Such circumstances may include mandatory notification of parents, as discussed above. More commonly, however, the obligation to disclose arises when a health care provider suspects physical or sexual abuse or a situation in which a minor presents a severe danger of harm to her/himself or others, as in the case of suicidal ideation. For example, every state has enacted a child abuse reporting law,[72] and SBHC/SLHC staff in most cases would be bound by such a law.

Confidentiality for specific medical services

In addition to the laws which generally protect confidentiality or provide for parental notification, there are also a number of state laws that govern patient

confidentiality with respect to certain medical services, particularly family planning, STDs and HIV/AIDS, alcohol and drug abuse treatment, or mental health services. Once again, the rationale for maintaining minors' confidentiality is to encourage them to seek treatment for serious health issues when they might be dissuaded from doing so by a requirement that their parent or guardian be notified. In truth, a minor facing an STD, drug or alcohol, or serious mental health problem probably does not distinguish between parental notification and parental consent—the mere possibility that a parent or guardian would learn about the problem may be enough to discourage the minor from seeking help.

State law sometimes provides, therefore, that the person responsible for treating a minor for alcohol or drug abuse may not release such information without the patient's consent.[73] Similar restrictions are applied to treatment for STDs[74] and mental or psychological problems.[75] Once again, the serious nature of these health problems, coupled with the "chilling" effect parental notification requirements would have on minors seeking treatment and counseling, are judged to outweigh the interests of the parents.

3. Drug and alcohol abuse programs and confidentiality

In 1987, the Department of Health and Human Services (HHS) issued rules for federally-funded drug and alcohol abuse programs regarding minor's confidentiality.[76] These regulations prohibit the parental notification of a minor's application for treatment without the minor's written permission in states where the law permits minors to obtain drug or alcohol treatment without parental consent.[77] In states where the law requires parental consent for drug and alcohol abuse treatment of minors, a minor's application can only be communicated if the minor gives written consent, or if the minor lacks the capacity for rational choice "regarding consent for treatment and the minor's situation poses a substantial threat to him/herself or others that would be alleviated by notification."[78] These regulations apply to any program that receives federal funds, so a SBHC/SLHC providing drug and alcohol abuse treatment and receiving federal funding is bound by these standards.

4. HIV/AIDS and confidentiality

With the spread of HIV and the concern over discrimination against people having or suspected of having HIV/AIDS, most states have passed laws addressing testing, treatment, or reporting of the disease. While there is a recognized need for people infected with HIV, or at risk for infection, to receive prompt testing and treatment, policy makers and legislators also realize that keeping information regarding a person's HIV status confidential is critical. There are many examples of discrimination against people who are HIV-positive, or believed to be HIV-positive. In light of these concerns, states have passed laws governing the confidentiality and disclosure of HIV/AIDS information. These statutes are important for SBHC/SLHCs in that they mandate certain reporting requirements and often set specific standards for handling minors who seek testing and treatment for HIV/AIDS. In addition, the federal Ryan White CARE Act includes a requirement that states must have laws in place to protect the confidentiality of HIV-related information.[79]

All but two states instruct health care providers to report cases of HIV infection or AIDS to the responsible state public health authorities.[80] The information contained in these reports is to be kept strictly confidential.[81] State statutes vary widely with respect to the question of whether, and to whom, HIV/AIDS-related

information may be disclosed, although it is common for states to specify that a patient's HIV information may be disclosed to other health care providers treating the patient.[82]

Important differences among the states concern minors and HIV, and specifically HIV-infected minors in schools. Obviously, these discrepancies are significant to SBHC/SLHCs. States may allow a health care provider to test and treat a minor without parental consent, but may still allow parental notification of the minor's HIV status. There may also be requirements that HIV-related information be reported to the state public health authority for transmittal to the school district. Provisions for the sharing of information among health care providers or with school personnel may also vary. In some states notification of partners may be either required or permitted. HIV/AIDS is an area of the law that is evolving rapidly. In such an unsettled area of the law, SBHC/SLHCs must consult legal counsel, state and local health authorities, and school officials to determine what specific requirements apply to HIV/AIDS information in the SBHC/SLHC's jurisdiction.

B. School Records and Medical Records

As previously discussed, the confidentiality of medical records is treated specifically under a variety of state and federal laws.[83] There are also state and federal statutes regarding the confidentiality and disclosure of school records, and the treatment of these records is quite different from the treatment of medical records. One area of confusion for SBHC/SLHCs is this disparate approach to school records and the clinic records, particularly since school records often contain health information, and some clinics are run by school districts rather than health departments.

Federal laws, such as the Federal Privacy Act, [84] the federal confidentiality regulations for drug and alcohol programs, and certain funding statutes, afford particular medical records the protection of strict confidentiality, but there are also federal rules for school records. The Buckley Amendments to the General Requirements and Conditions Concerning the Operation and Administration of Education Programs[85] — usually known simply as the "Buckley Amendments" — do not allow federal funds to be made available to schools that deny parents the right to inspect or review their child's school records.[86] Furthermore, funds will not be provided to schools that permit release of students' school records without parental consent.[87] Since every state currently receives federal education funding, these parental access and consent provisions have been universally adopted.[88] The rationale behind the requirements is that parents have an important interest in the education and development of their children and are, therefore, entitled to check on their educational progress.

Thus federal law provides parents broader access to a minor's school records than to a minor's medical records. A review of a sample of state statutes governing school records illustrates the complexities. In Connecticut, for example, the law stipulates that a parent or guardian is entitled to access to a child's records (including educational, medical, or similar material) maintained by the school in the student's "cumulative record."[89] This provision, including the identification of medical information maintained by the school (that might otherwise be contained in medical records), is similar to standards in other states.[90] Of particular interest to a SBHC/SLHC, then, is what is included in this medical information. Connecticut, like other states, requires that students be vaccinated and have standard physical examinations before they are allowed to enroll in the

public schools.[91] These health assessments should include: a physical examination; updated immunizations; vision, hearing, and dental screening; and "such other information including health and developmental history as the physician feels is necessary and appropriate."[92] This health information is then made part of the student's "cumulative record" to which the student's parent or guardian has access—with or without the student's consent.

SBHC/SLHC advocates and staff should note the distinctions made under the law between health records and school records. The records maintained by the SBHC/SLHC are medical records and are subject to the stricter standards of confidentiality applied to medical information. The school's records, even though they may contain some standard medical history, are more accessible to parents. For this reason, an SBHC/SLHC should hold its records separate from the school's records.

There are also cases where the SBHC/SLHC is run by the school itself. In these situations, it is essential to clarify which medical records are or are not part of the school records. Depending upon specific provisions of state law, there may be some information (e.g., information related to STD, drug and alcohol abuse, or mental health services) to which a parent's access would be more limited than to school records in general. Procedures are needed to distinguish between the information that is and that is not accessible to parents. In some jurisdictions, school officials may have access to some of the clinic's records, but the principles of confidentiality may require more limited access to health information. Record-keeping and information disclosure procedures for a SBHC/SLHC must be formalized by clinic staff, in consultation with legal counsel and school authorities, to ensure that confidentiality is protected, and that unauthorized access is prohibited.

C. Conflicting Confidentiality Requirements and SBHC/SLHC Practice

Clearly, there are myriad state and federal sources on confidentiality requirements in health care. The challenge for a SBHC/SLHC is to determine which legal requirements apply in each situation. Most important, each situation in which confidentiality or disclosure may be at issue must be evaluated on a case-by-case basis. For example, confidentiality restrictions may vary when different services are involved, either because the service itself has particular confidentiality requirements associated with it (e.g., HIV/AIDS services) or because the service may be funded by the federal government (e.g., treatment for drug and alcohol abuse). One possible approach would be to compile a list of the applicable confidentiality laws and requirements and, with the help of legal counsel, create scenarios in which confidentiality would be at issue. By working through these potential situations, SBHC/SLHC staff and advocates will be familiar with the laws that are applicable in their jurisdiction and prepared for the unexpected.

CHAPTER FOUR:

LIABILITY

As previously noted, liability is probably the issue that most concerns SBHC/SLHC staff and advocates. To date Advocates for Youth is not aware of any successful liability claim brought against a SBHC/SLHC. Nevertheless, a common response from state and local officials to the idea of setting up a SBHC/SLHC is "We can't because we'll be liable."

1. Types of liability

The two most common types of liability of which a SBHC/SLHC must be aware are liability for damages and injunctions. When liability for damages is imposed, a party which has committed a legal wrong must pay "actual damages" to make another "whole" and, in some cases, "punitive damages" as a penalty to ensure that the party will not repeat its illegal action:

> [Damages are] the sum of money which the law awards as compensation for an injury done or a wrong sustained. [They] are the pecuniary consequences which the law imposes for the breach of some duty or the violation of some right.[93]

Damages are the remedy commonly sought in actions for breach of contract or negligence. For example, a SBHC/SLHC could face a suit for damages in a case alleging lack of consent for treatment and claiming that the center was negligent because it failed to obtain the proper consent. Alternatively, a SBHC/SLHC itself or one of its health care providers might face a claim for negligence in a case of medical malpractice.[94]

The second type of liability of which a SBHC/SLHC must be aware is liability for injunctive relief. An injunction is usually the remedy sought for violation of a duty defined by the common law or by statute, particularly when money damages are not available or would not be effective in remedying the violation:

> An injunction is a formal command by a court directing the persons named to refrain from doing certain specified acts, or commanding them to take certain actions to undo the wrong or injury with which they are charged.[95]

An example for SBHC/SLHCs would be a case in which a center is providing services without complying with the requirements of a funding statute under which it received funds. A party seeking to stop the center from doing so would seek an injunction from a court ordering the SBHC/SLHC to cease providing services without complying with the statutory requirements or to comply with those requirements in the future.

A third type of liability is for violation of criminal statutes. There are some statutes applicable to SBHC/SLHCs which contain criminal penalties for violations. For example, Michigan prohibits the distribution of contraceptives and referrals for abortions in public schools.[96] Any person who violates this statue is guilty of a misdemeanor, punishable by imprisonment of up to 90 days, or a fine up to $500, or both.[97] Similarly, many states impose criminal penalties for failure to comply with child abuse reporting laws.

2. Determining who is liable

The question of whether a SBHC/SLHC, a school, or an individual would be liable for violations of certain legal requirements depends on a number of factors. A particular statute or regulation may explicitly assign responsibility for violations to a certain individual (e.g., child abuse reporting laws impose liability on the individuals who are mandated to report abuse but fail to do so). State statutes creating SBHC/SLHC programs usually identify the parties who are responsible for actions at the SBHC/SLHC. For example, state employees of SBHC/SLHCs in Arkansas are subject to the supervision and control of the local school board.[98] Because the law states that the school board has control over the actions of the SBHC/SLHC employees, any liability for their actions might fall upon the board. In contrast, the Mississippi school nurse intervention program assigns supervision and control of employees to the State Department of Health,[99] possibly making the department liable for the actions of the nurses under its direction.

Some liability questions can be resolved by referring to the contractual agreement between the SBHC/SLHC and the school, which might specifically address certain liability issues, assigning responsibility to one or both parties. Here again, the assistance of legal counsel is essential to address questions of a SBHC/SLHC's potential liability comprehensively and in a manner that is consistent with potentially conflicting legal requirements.

3. What law determines liability?

Federal and state law sometimes present conflicting mandates for SBHC/SLHC practice. Should a SBHC/SLHC follow federal, state, or local law in the different areas of its practice? If the center follows one law that conflicts with another, can the center still be held liable for damages or an injunction?

Article VI, Section Two of the United States Constitution states: "This Constitution, and Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land." With this pronouncement, the Constitution makes federal law the controlling source of legal authority in the United States: In a conflict between state law and federal law, it would seem that federal law should take precedence over state law. Unfortunately, as with many things in the law, the reality is not as simple as the previous statement indicates. There is an enormous body of Supreme Court jurisprudence, federal case law, and scholarly work on the question of whether, and when, state law or federal law controls a particular case. Even a cursory review of this area of the law is beyond the scope of this document, but a few examples are included to illustrate the reasoning the Supreme Court has applied to questions of conflict of laws and which authority—federal or state—applies to particular cases.

The Supreme Court has said that federal laws must be recognized and enforced by state courts because "the Constitution and laws passed pursuant to it are as much laws in the States as laws passed by the State legislature."[100] This proposition is further supported by the doctrine of federal preemption.[101] Under the preemption doctrine, state law is outweighed by a federal statute if Congress has shown an intent to control a particular field with its own legislation.[102] Even if Congress has not entirely displaced state regulation, state law is still preempted if it actually conflicts with federal law, or if the state law presents an obstacle to achieving the objectives of Congress.[103] Generally, state regulations may supplement federal law so long as compliance with federal law is not impeded by the state regulations.[104]

Of course, ascertaining Congress' precise objectives is often a matter of interpretation, but there are examples applicable to SBHC/SLHCs where federal law appears to control. For example, in federally-funded drug and alcohol abuse programs, as described above, HHS has provided specific guidelines for notification of a minor's parent or guardian when a minor applies for treatment.[105] State requirements applicable to minors seeking drug and alcohol abuse treatment that conflict with these federal rules would appear to be overridden by the federal requirements. If so, this would represent a case in which state law must yield to federal law.

Nevertheless, many cases of conflicts are not so clear. In fact, it is often difficult to tell whether a particular state statute conflicts with a federal law. The only way a SBHC/SLHC can protect itself from uncertainty is to consult local counsel as to what law controls in different situations, and particularly how local courts interpret conflicting laws.

As much dispute as there is among courts, legislators, and legal scholars over conflicts between federal and state law, there may be even greater uncertainty about state and local differences. A few general principles, however, provide guidance. In dealing with school districts and administrators, SBHC/SLHC advocates and staff should remember that these entities are considered creations of the state government and are given their authority by the state.[106] For example, California law allows school boards to "prescribe and enforce rules not inconsistent with law, or with the rules prescribed by the State Board of Education,"[107] but local school boards have no authority to enact rules that "alter or enlarge" the terms of the state law.[108] The board cannot adopt rules inconsistent with state statutes, only rules that supplement a state statute to make it workable.[109] Thus, where a local ordinance conflicts with a state law, the state law would control in California.

The scope of an individual school board's responsibility and autonomy will vary with each state's statutes. Thus, one state may explicitly forbid a school board from regulating certain areas, while another state gives their school boards more discretion in governing school affairs. SBHC/SLHCs need to work with their legal counsel and local school officials to ensure that each party understands their rights and responsibilities.

CHAPTER FIVE:
FUNDING FOR SBHC/SLHCS: REGULATIONS AND REQUIREMENTS

One of the most important sources of rules and regulations for SBHCs/SLHCs is funding statutes. Whether the center is supported by the state or federal government, or both, the laws authorizing funding will contain restrictions upon the use of funds. Since a SBHC/SLHC cannot operate without financial support, the regulations contained in the relevant funding statutes should be one of the first places staff and advocates look for rules prescribing or limiting the center's conduct.

A. Federal Funding for SBHC/SLHC

A variety of federal programs support SBHC/SLHC activities. These programs include the Maternal and Child Health Services Block Grant;[110] Medicaid;[111] the Title X Family Planning program;[112] the Alcohol, Drug Abuse and Mental Health Services Block Grant;[113] and the Community Health Center[114] program. As with any federal program, each one contains numerous regulations and procedures for applying and qualifying for and maintaining funding. In view of the political climate at the federal level, however, federal funding requirements may change, in substance or in emphasis. For example, Congress has debated whether or not to transform Medicaid into a block grant program — a lump sum award of funds from the federal government to the states for their use on specific issues. If the states are given increased authority over expenditure of federal funds, the particular laws and regulations of each state will increase correspondingly in importance. The issue of federal funding is fluid and predicting what will happen to federal funding for SBHC/SLHCs in the future is impossible. Therefore, this document focuses on federal requirements as they currently exist.

Advocates for Youth has published other resources to detail federal funding sources for SBHC/SLHCs,[115] so the discussion here will be limited mainly to highlighting certain consent and confidentiality requirements contained in federal funding statutes. (For a more detailed discussion, see the Consent and Confidentiality sections above.)

Title V of the Social Security Act: Maternal and Child Health (MCH) Services Block Grant

Congress created the MCH Services Block Grant in 1981 by consolidating eight programs related to the health of children, pregnant women, and mothers. Funds are allocated to states based on the proportion of low-income U.S. children who live in the state. States are required to match every four dollars received under the program with three dollars of the state's money.[116] States use Title V funds to support SBHC/SLHCs. SBHC/SLHCs also receive Title V monies indirectly when they are sponsored by public health departments or other recipients of Title V funds.[117]

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The SAPT Block Grant supports services, programs, and activities to prevent or treat alcohol and other drug abuse. At least 20 percent of the SAPT funds must

be used for primary prevention programs: services, programs, and activities for individuals not in need of treatment for substance abuse, which either educate or counsel these individuals about substance abuse or involve them in activities which reduce their risk of alcohol or other drug abuse.[118] Among the restrictions placed on these funds is a requirement that grant recipients adhere to state confidentiality requirements for records.[119]

Title XIX of the Social Security Act: Medicaid

Medicaid[120] is the single largest source of federal funding for health services for low-income children and adolescents, but because of several administrative features of the program, SBHC/SLHCs have been hindered in using Medicaid funding. The Medicaid program is operated jointly by the states and the federal government, but each state has some flexibility to determine eligibility, covered services, rates of provider reimbursement, and operational procedures.[121] The federal Medicaid statute is among the most detailed and complex of federal statutes providing for the funding of health care services. Medicaid differs from other federally funded health programs because it operates, in effect, as an insurance program for low-income individuals. Entities, such as SBHC/SLHCs which provide services to Medicaid clients, may be reimbursed or paid for these services if they are certified by the state as Medicaid providers. Family planning is one of the mandatory services which all states must offer to Medicaid recipients.[122] Medicaid financing of services is undergoing rapid changes as states shift to using managed care for their Medicaid populations.[123]

Title X: Grants for Family Planning Services

Under Title X of the Public Health Service Act, the federal government makes grants to public and private nonprofit organizations to provide voluntary family planning services: educational, medical, and social services to assist individuals to determine freely the number and spacing of children. Title X funds may be used for information, education, counseling, physical examinations, laboratory tests, contraceptive supplies, general reproductive health care, and diagnosis and treatment of infections which threaten reproductive health. Funds may not be used to provide abortions or promote the availability of abortion services, although counseling about options is permissible.[124]

1. Consent requirements in federal funding statutes

Title X and Medicaid affect the provision of family planning services for minors. Requiring parental consent for the provision of contraceptive services to minors would be, in effect, inconsistent with each of these statutes, for varying reasons.[125] SBHC/SLHCs that provide family planning services and receive federal funding under one or more of these statutes, therefore, must consult with local counsel to determine how best to adapt their consent forms and clinic policies to be consistent with the requirements of these laws.

2. Confidentiality requirements in federal funding statutes

Federal funding statutes have specific confidentiality requirements that apply to SBHC/SLHCs. For example, the Maternal and Child Health Services Block Grant;[126] Alcohol, Drug Abuse and Mental Health Services Block Grant;[127] and the Community Health Center[128] Program all have strict confidentiality rules which forbid disclosure of information without the consent of the individual receiving services. Information gathered through a Title X-funded program is

also confidential and cannot be released without the consent of the individual.[129] Therefore, SBHC/SLHC staff must consult with an attorney to ensure that the clinic's practice and procedures are consistent with these requirements.

B. State Funding Statutes

SBHC/SLHCs may receive state funds for family planning, drug and alcohol abuse, mental health, and STD or HIV/AIDS-related services. In addition, a number of states have enacted SBHC/SLHC legislation delineating the services to be funded by the state and, to a greater or lesser extent, defining what services may be offered at a center. There is wide variation among states in their treatment of SBHC/SLHCs. The following discussion presents examples of state statutes pertaining to SBHC/SLHC or related systems of care.

1. Arkansas

The Arkansas SBHC/SLHC statute[130] is unique in the authority it grants to local school boards over SBHC/SLHCs. Under this law, no SBHC/SLHC can be established unless the local school board requests, in writing, permission from the State Department of Health to create one.[131] A school board that establishes a SBHC/SLHC retains "absolute control" over the operations and programs offered by the clinics.[132] Any Department of Health employee working at the SBHC/SLHC is subject to the supervision and control of the local school board.[133] The school board also has sole authority over whether and to what extent family planning education is provided in SBHC/SLHCs, "including any purchase and distribution of contraceptives,"[134] although the law forbids the use of state funds for the purchase of contraceptives or abortifacients.[135]

Arkansas law also defines parental consent and confidentiality regulations for SBHC/SLHCs. Once a clinic is established, no student may receive services without parental consent, and no client may receive contraceptive services at the SBHC/SLHC unless parental consent has been obtained in writing and is maintained in the student's health records.[136] Records maintained at the SBHC/SLHC become part of the student's confidential health record—making them unavailable for disclosure to school personnel.[137]

2. Kentucky

A Kentucky statute authorizes the development of a five-year implementation plan to establish "Family Resource and Youth Services Centers,"[138] a model of care similar to SBHC/SLHCs. The plan calls for setting up centers throughout the state. The centers are to be in or near schools, serve youth over 12 years of age, and be established in areas where 20 percent or more of the student body is eligible for free school meals.[139] The services are to include, but not be limited to, referrals to health and social services; employment counseling, training and placement; summer and part-time job development; drug and alcohol abuse counseling; and family crisis and mental health counseling.[140]

The statute establishes a grant program to fund the centers.[141] Grants applications must describe procedures for obtaining parental permission for services, and for sharing confidential information with other service providers.[142] These procedures must be developed "pursuant to federal [and state law] and shall require that no . . . center offer contraceptives to minor students prior to receiving the express consent of the student's parent or legal guardian."[143] Kentucky forbids centers to provide abortion counseling or referrals.[144]

3. Louisiana

As in Arkansas, the Louisiana legislature grants local authorities a large measure of control over SBHC/SLHCs. Under this system, the state aids and assists local school boards who wish to set up SBHC/SLHCs by providing information, technical assistance, direction, and to the extent appropriate, funding.[145] "The [Louisiana] Office of Public Health shall [also] apply for and assist local efforts to apply for all available public and private funds [for SBHCs]."[146] All SBHC/SLHC initiatives are "subject to the approval of the local school systems."[147] Despite this control, the state prohibits centers from distributing any contraceptive or abortifacient drug, and from counseling or advocating abortion, or referring a student to any organization that counsels or advocates abortion.[148]

4. Florida

Florida directs funding for SBHC/SLHCs based on need.[149] The statute makes funds available to school districts with high incidences of medically underserved children, high-risk children, low birth weight babies, infant mortality, and teenage pregnancy.[150] The legislature emphasizes local participation by mandating that funds are available only for programs that are developed jointly by county public health units and local schools and have community and parental support.[151] The centers must offer referrals to care for drug and alcohol abuse and STDs, as well as "effective preventive services aimed at delaying early sexual involvement and aimed at pregnancy, AIDS, STDs and . . . alcohol and drug abuse."[152]

5. Missouri

Missouri gives strict instructions for consent forms to be used at SBHC/SLHCs.[153] According to state law, the operator of a SBHC/SLHC must include a checklist of all services offered by the center and request that the parent or guardian specify the services which may not be provided to their child.[154] If the school includes referral for contraceptive devices and prescriptions, the checklist must include a specific item stating services may include referral to the family doctor for contraceptives, and "no referral . . . shall be made unless the parent, guardian or legal custodian affirmatively selects such services."[155] To this end, school officials must make a reasonable effort to identify the minor's family practitioner.[156] When a minor seeks contraceptives, s/he must be referred to the previously identified family practitioner.[157]

Each of these state statutes places conditions on the receipt of state funding for SBHC/SLHCs. Whether by forbidding the use of funds for distributing contraceptives or by maintaining authority over SBHC/SLHC practice through state agency supervision, state funding statutes do not simply give money to local agencies to use as they see fit. A SBHC/SLHC seeking state support for its activities must be aware of the limitations the state may place on the health center's services. In addition, federal funding may come with additional—or conflicting—restrictions. It is critical, therefore, for advocates and staff to work with federal, state, and local authorities prior to establishing a center and initiating the provision of health services to ensure that the SBHC/SLHC meets all of the applicable funding criteria. In the complex web of federal and local funding regulations there is simply no substitute for the assistance of local counsel.

CHAPTER SIX:

CONCLUSION

The legal framework under which SBHC/SLHCs operate is a constantly evolving set of federal, state, and local laws, but the system is not so complex that staff and advocates must be totally uninformed as to their responsibilities under the law. Indeed, individuals involved in SBHC/SLHC practice can, and should, take an active role in learning about the law and working to adapt it to the needs of their center and clients. This document provides a starting point for the inquiry into the law governing adolescent health care and to facilitate a better understanding of the legal principles which regulate SBHC/SLHC practice.

In light of the current political debate at the federal level, state laws and regulations may become even more important for SBHC/SLHCs. Congress has sought to return funding and control over a great many social programs to the states for them to administer as they see fit, although as of this writing it has not succeeded in bringing about wholesale changes in certain programs such as Medicaid. Developments in federal law, however, must be carefully monitored to determine whether additional authority and discretion is granted to the states. In the next few years, SBHC/SLHCs may continue to face significant changes in the legal framework under which they operate. It is important, now more than ever, for staff and advocates to familiarize themselves with the applicable laws in their jurisdiction, and keep abreast of changes as they occur. Changing laws will affect SBHC/SLHC practice, and only by staying knowledgeable about the law can SBHC/SLHC practitioners provide their clients with the best services possible.

APPENDICES

Appendix A: Blanket Consent Form #1

Appendix B: Blanket Consent Form #2

Appendix C: “Opt Out” Consent Form #1

Appendix D: “Opt Out” Consent Form #2

Appendix A: Blanket Consent Form #1

This is a ***sample*** *consent form. Actual consent forms should be made with the consult of legal counsel.*

JOHN DOE HIGH SCHOOL-BASED HEALTH CENTER IN STATE X
PARENTAL CONSENT FORM

The John Doe High School-Based Health Clinic is concerned with the health and well-being of its teenagers. Despite the wide range of their health and social needs, many adolescents in the city do not regularly receive the health services they require. It is the purpose of the clinic to provide many of these services to them.

The John Doe High School-Based Health Clinic will be offering the following health services which are explained more fully in the accompanying brochure:

- Routine physical examinations for sports, jobs, Special Olympics
- Treatment of minor illnesses and injuries, including laboratory screening examinations as needed by the physician and/or nurse practitioner to assist in diagnosis of a particular medical problem
- Preventive health education
- Immunizations
- Referrals

PLEASE READ CAREFULLY AND SIGN THE CONSENT FORM IN ORDER FOR YOUR CHILD TO RECEIVE HEALTH SERVICES AT THE CLINIC.

I hereby voluntarily give my consent for _____
Name of Child

to receive the health services offered by the Adolescent Health Clinic. I further authorize any physician or physician-designated health professional employed by or working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care. I have provided a medical history of my child through completion of the attached history form.

I have read and understand the above statements and give permission for my child's care as described. I also understand that further information regarding the health services offered by the clinic may be obtained by contacting the clinic at 222-2222.

_____ _____
Name of Parent or Legal Guardian (type or print) | Child's Name

_____ _____
Sign: (Parent or Legal Guardian) | Signature of Witness

Date: _____ Date: _____

Under Section X of the State X Code, a minor has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. These services, which include diagnosis and treatment of venereal disease, family planning, and medical and health services related to substance abuse, mental illness, and emotional disturbance, will also be offered by the health clinic.

APPENDIX B: Blanket Option #2

This is a **sample** *consent form. Actual consent forms should be made with the consult of legal counsel.*

Somewhere City Health Department, State Y

Name:_____ Student ID#:_____

Address:_____ Phone: _____

Birth Date: _____Soc. Sec #: _____ Grade ____ School # _____

Name of Parent/Guardian_____ Day Phone: _____

If Emergency Call _____ Day Phone: _____

I grant permission for my child, _____, to enroll in the school-based health center. I consent to his/her receiving health services which can include complete physical examinations, treatment for chronic and acute health problems, health education, mental health counseling, and limited diagnostic tests, eg, throat cultures, blood work. I give my consent for submission of all claims to my private health care insurer (if applicable) and authorize direct payment to the Somewhere City Health Department for any medical benefits due.

I understand that State Y law allows a minor to give consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, and treatment or advice about birth control. A minor 16 years or older may consent to mental health services.

I understand that school personnel will not have access to any of my child's medical records and the results of all examinations and counseling are strictly confidential. I understand that if I belong to another clinic, this health center can supplement that care.

Signature of Parent/Legal Guardian: _____ Date _____

INSURANCE INFORMATION:

1. If your child has public medical assistance, please complete the following:

Medical Assistance #_____

HMO Card? ___yes ___no ___Prudential ___Total Health Care ___Chesapeake ___Optimum Choice

Does your child have a MAC provider ___yes ___no

Provider Name:_____ Phone: _____

Do you want the school-based health center to be your child's MAC provider? ___yes ___no

2. If your child has private insurance, please complete the following:

Name of policyholder _____ Relationship to Child: _____

Policyholder's Social Security or ID #: _____

Employer's Name, Address, and Phone:_____

Name of Insurance Company _____Group #_____ Policy #_____

Mail Claims to: (see address on back of insurance card):

_____

A CHILD WILL NEVER BE DENIED SERVICES BECAUSE OF INABILITY TO PAY

APPENDIX C: "Opt-Out" Format #1

This is a **sample** *consent form. Actual consent forms should be made with the consult of legal counsel.*

ANYTOWN HIGH SCHOOL-BASED HEALTH CENTER

Dear Parent or Guardian,

We are pleased to announce that the Anytown School District and the Anytown Medical Center have received funds to provide free comprehensive medical and mental health services and counseling for teenagers who attend Anytown High. This means that your child can obtain, with your permission, a wide range of services including health screening and physicals, personal counseling, health and substance abuse counseling, and a variety of school and community education programs. In respect to the individual clients, all interactions between the providers and teens will be kept confidential.

Eligible teens may receive any of the available services with parental consent. Please sign below to give your child permission to receive services. If your family is eligible for Medicaid, please provide the appropriate information below. We look forward to serving you and your teenager.

Services Available

Medical: general health assessment, immunizations; sports and job physicals; problem screenings and referrals; laboratory and diagnostic screenings; pregnancy testing, counseling, and education; family planning education, counseling, and referrals; sexually transmitted disease testing, treatment, and counseling; nutrition counseling.

Personal Counseling: general screening, counseling, and referral for various concerns related to teenagers including depression, behavior disorders, personal relationships, and family problems.

Health Education: various school and community programs relating to teen health issues.

Date _____

I, _____(parent or guardian), consent to have

_____(full name of child) receive services provided by the

School-Based Health Center Program at Anytown High School.

_____
Signature of Parent or Guardian

While I consent to have services provided to my child, I do not want him/her to receive the services I have noted below:

_____

Does your son/daughter use a family doctor? yes _____ no _____

If so, please indicate name and telephone number below:

_____

(Name and phone number)

If you have a Medicaid number, please provide it: _____

APPENDIX D: "Opt-Out" Format #2

This is a **sample** *consent form. Actual consent forms should be made with the consult of legal counsel.*

JANE DOE MIDDLE SCHOOL-BASED HEALTH CENTER
PARENTAL CONSENT FORM

PLEASE READ CAREFULLY AND COMPLETE THE FOLLOWING CONSENT STATEMENT AUTHORIZING YOUR SON/DAUGHTER TO RECEIVE SERVICES AT THE ADOLESCENT WELLNESS CENTER.

I give consent for my daughter/son _____, born on _____, to receive the following services at the Jane Doe Middle School-Based Health Center.

These are the services that are provided at the health center:

- Comprehensive health history
- Physical examination
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems
- Management of chronic illnesses
- Early periodic screening, diagnosis, and treatment (EPSDT)
- Substance abuse prevention, education, support, referral

Please list any of the above services that you do not wish to be provided for your child:

_____

I permit the Jane Doe Middle School-Based Health Center to provide transportation from school to a health provider if and when the need arises.

I understand that the confidentiality of the patient's medical record is required by law, and the record will not be released to any person or entity, other than the health care provider, without prior permission.

Parent/Guardian: _____ Date: _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

Signature:_____ Parent/Guardian)

I, the student, have read this form, and it has been fully explained to me.

Student Signature: _____ Date: _____

SELECTED RESOURCES

For additional information on legal issues for SBHC/SLHCs, consult the following materials:

General

English A, and Tereszkiewicz L. *School-Based Health Clinics: Legal Issues.* San Francisco, CA: National Center for Youth Law, 1988.

Holder AR. *Legal Issues in Pediatric and Adolescent Medicine.* 2d Ed. New Haven: Yale University Press, 1985.

Morrissey JM et al. *Consent and Confidentiality in the Health Care of Children and Adolescents: A Legal Guide.* New York: The Free Press, 1986.

Office of Technology Assessment. *Adolescent Health, Vol. III: Crosscutting Issues in the Delivery of Health and Related Services.* Washington, D.C.: U.S. Govt Printing Office, 1991.

Consent

The Alan Guttmacher Institute. Lawmakers grapple with parents' role in teen access to reproductive health care. *Issues in Brief* 1995 (November).

English A et al. *State Minor Consent Statutes: A Summary.* Cincinnati, OH: Center for Continuing Education in Adolescent Health; San Francisco, CA: National Center for Youth Law, 1995.

Paradise E, Horowitz R. *Runaway and Homeless Youth: A Survey of State Law.* Washington, DC: ABA Center on Children and the Law, 1994.

Confidentiality and Medical Records

Roach WH, Aspen Health Law Center. *Medical Records and the Law.* 2d ed. Gaithersburg, MD: Aspen Publishers, 1994.

Soler MI et al. *Glass Walls: Confidentiality Provisions and Interagency Collaborations.* San Francisco: Youth Law Center, 1993.

HIV

Teare C, English A, eds. Protecting adolescents in the HIV epidemic: the urgency increases. *Youth Law News* 1995; 14(3):1-25.

Wever DW, ed. *AIDS and the Law.* 3rd ed. New York: Wiley Law, 1997.

REFERENCES

1. AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE 278 (1995) [hereinafter Legal Medicine].
2. *Id.*
3. Elizabeth Cauffman & Laurence Steinberg, *The Cognitive and Affective Influences on Adolescent Decision-Making*, 68 TEMPLE L. REV. 1763, 1765 (1995).
4. LEGAL MEDICINE, *supra* note 1 at 276.
5. *See, e.g.,* U.S. OFFICE OF TECHNOLOGY ASSESSMENT, ADOLESCENT HEALTH - VOL. III: CROSSCUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES 123 (1992) [hereinafter ADOLESCENT HEALTH].
6. *Id.* at 125.
7. *Id.*
8. *Id.*
9. LEGAL MEDICINE, *supra* note 1, at 283.
10. *See, e.g.,* N.H. REV. STAT. ANN. §151-B:16 (1996); N.C. GEN. STAT. §90-21.1(1993); 35 PA. CONS. STAT. §10104 (1996).
11. *See, e.g.,* ADOLESCENT HEALTH, *supra* note 5, at 126.
12. See pages 5-6.APPENDIX A:
13. LEGAL MEDICINE, *supra* note 1, at 276.
14. ABIGAIL ENGLISH ET AL., STATE MINOR CONSENT STATUTES: A SUMMARY (1995) (hereinafter STATE MINOR CONSENT STATUTES).
15. Sanford N. Katz, et al., *Emancipating Our Children: Coming of Legal Age in America, 7* FAM. L. QUARTERLY 211 (1973).
16. *E.g.,* CAL. FAM. CODE §7002 (West 1994); CONN. GEN. STAT. ANN. §46b-150b (West 1995); S.D. CODIFIED LAWS ANN. §25-5-24 (1992).
17. *E.g.,* LA. CIV. CODE ANN. art. 365 (West 1993); MD. CODE ANN., HEALTH-GEN. §20-102(e) (1996); MONT. CODE ANN. §41-1-402(1)(a)(1995).
18. *See, e.g.,* ALA. CODE §09.55.590 (1994); ARK. CODE ANN. §9-26-104 (Michie 1993); FLA. STAT. ANN. §743.015 (West Supp. 1996); ILL. REV. STAT. ch. 750 §30/3-2 (1993); LA. CIV. CODE ANN. art. 368, 385 (West 1993); TEX. FAM. CODE ANN. §31-001 - 31.007 (1996).
19. ARK. CODE. ANN. §20-9-602(6) (Michie Supp. 1996); KY. REV. STAT. ANN. §214.185(3) (Michie 1992).
20. See pages 6-7.
21. ARK. CODE ANN. §20-9-602(7); MISS. CODE ANN. §41-41-3(h) (1993); N.H. REV. STAT. ANN. §318-B:12a (1995).
22. In re Doe, 866 P.2d 1069, 1074 (Kan. App. 1994).
23. ADOLESCENT HEALTH, *supra* note 5, at 127. The Supreme Court of the United States has utilized the mature minor doctrine in its abortion jurisprudence (discussed below at 8).

24. ABIGAIL ENGLISH AND LILLIAN TERESZKIEWICZ, SCHOOL-BASED HEALTH CLINICS: LEGAL ISSUES 10 (1988) [HEREINAFTER SBHCs](*citing,* J. MORRISSEY ET. AL., CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS: A LEGAL GUIDE 47 (1986)).
25. STATE MINOR CONSENT STATUTES, *supra* note 14.
26. Griswold v. Connecticut, 381 U.S. 479 (1965).
27. Eisenstadt v. Baird, 405 U.S. 438 (1972).
28. Carey v. Population Services International, 431 U.S. 678 (1977).
29. Roe v. Wade, 410 U.S. 113 (1973).
30. Belotti v. Baird, 443 U.S. 622 (1979); Planned Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976).
31. Belotti at 637.
32. *Id.* at 633 (*quoting* In Re Gault, 387 U.S. 1, 13 (1967)).
33. *Id.* at 635.
34. STATE MINOR CONSENT STATUTES, *supra* note 14.
35. Planned Parenthood Association of Utah v. Dandoy, 810 F.2d 984 (10th Cir. 1987).
36. Jane Does 1 Through 4 v. State of Utah Department of Public Health, 776 F.2d 253 (10th Cir. 1985).
37. Planned Parenthood v. Casey, 112 S.Ct. 2791, 2832 (1992); Belotti at 643. There are two states, however, where the state courts found that parental consent restrictions on abortion in their statutes violated the *state's* constitution (American Academy of Pediatrics v. Lungren, 1996 Cal. LEXIS 1387 has been stayed while a rehearing is pending; In re T.W., 551 So.2d 1186 (Fla. 1989)).
38. Casey at 2832.
39. Margaret C. Crosby and Abigail English, *Mandatory Parental Involvement/Judicial Bypass Laws: Do They Promote Adolescents' Health? 12* J. ADOLESCENT HEALTH 143 (1991) (*citing* BELLOTTI V. BAIRD, 443 U.S. 622 (1979).
40. *See, e.g.,* ME. REV. STAT. ANN. TIT. 22, §1597-A (WEST 1992).
41. Casey, 112 S.Ct. 2791.
42. H.L. v. Matheson, 450 U.S. 414 (1981).
43. Hodgson v. Minnesota, 497 U.S. 417 (1990).
44. Ohio v. Akron Center for Reproductive Health, 497 U.S. 543 (1990).
45. STATE MINOR CONSENT STATUTES, *supra* note 14; ADOLESCENT HEALTH, *supra* note 5, AT 127.
46. Exceptions are Alaska, Arkansas, Oregon, Utah, Wyoming, and the District of Columbia. ADOLESCENT HEALTH, *supra* note 5, AT 129.
47. STATE MINOR CONSENT STATUTES, *supra* note 14; ADOLESCENT HEALTH, *supra* note 5, AT 130.
48. LEGAL MEDICINE, *supra* note 1, AT 278.
49. ADOLESCENT HEALTH, *supra* note 5, AT 131.
50. *See, e.g.,* COLO. REV. STAT. § 25-4-1409(2) (Supp. 1996) (violating patient confidentiality is grounds for disciplinary action, including revocation of physicians license).

51. *See, e.g.,* MINN. STAT. §144.335 (SUPP. 1996).
52. 5 U.S.C. §552a (Federal Privacy Act); 45 C.F.R. §5b.6 (Special procedures for notification of or access to medical records); 42 C.F.R. §51a.6 (Title V Maternal Child Heath Services Block Grant Act); 42 C.F.R. §59.15 (Title X). For a more detailed discussion of the sources of the confidentiality obligation, see MARK I. SOLER ET AL., GLASS WALLS: CONFIDENTIALITY PROVISIONS AND INTERAGENCY COLLABORATIONS 11-14 (1993) (hereinafter GLASS WALLS).
53. 5 U.S.C. § 552a.
54. *Id.,* note 1.
55. Gilbreath v. Guadalupe Hospital Foundation, Inc. 5 F.3d 785 (5th Cir. 1993) (release of a federal employee's wife and son's medical records does not violate the Act because the hospital was not an "agency" of the federal government).
56. 5 U.S.C. §552a(b). "Agency" is defined as "any executive department, military department, government corporation, government controlled corporation, or other establishment in the executive branch of government (including the Executive Office of the President), or any independent regulatory commission." 5 U.S.C. §552(f).
57. 45 C.F.R. § 5b.6.
58. 45 C.F.R. § 5b.6(a).
59. 45 C.F.R. § 5b.6(c) (The statute does not specify the age of the minor).
60. *Id.*
61. There are similar confidentiality provisions for programs and clinics funded through the Title V Maternal and Child Health Services Block Grant Act: "All information obtained . . . shall be held confidential and shall not be disclosed without the individual's consent." (42 C.F.R. §51a.6). Title X programs have an identical provision. (42 C.F.R. §59.15).
62. 42 CFR § 51a.6 (MCH Services Block Grant Act) and 42 CFR § 59.15 (Title X).
63. GLASS WALLS, *supra* note 52, AT 12-13 (1993); SBHCs, *supra* note 21.
64. *E.g.,* COLO. REV. STAT. §25-1-801 (1989); FLA. STAT. ANN. §395.3025 (West 1993); HAW. REV. STAT. §622-57 (1993); MINN. STAT. ANN. §144.335 (West Supp. 1996); OKLA. STAT. ANN. tit. 76 §19 (West 1995).
65. FLA. STAT. ANN. §395.3025(4).
66. LEGAL MEDICINE, *supra* note 1, AT 337.
67. *E.g.,* COLO. REV. STAT. §25-4-1409(2) (Supp. 1996) (violation of patient confidentiality is grounds for disciplinary action).
68. *E.g.,* OKLA. STAT. ANN. TIT. 63 §2602 (West 1984).
69. *E.g.,* LA. REV. STAT. ANN. §40:1095 (West 1992).
70. MASS. GEN. L. CH. 112 §12F (1991); ME. REV. STAT. ANN. TIT. 19, §§903, 905 (West Supp. 1995); N.C. GEN. STAT. §90-21.4 (1993).
71. MONT. CODE ANN. §41-1-403 (1995).
72. *E.g.,* SBHCs, *supra* note 21, TABLE 6.

73. *E.g.,* FLA. STAT. ANN. §397.501(7) (West Supp. 1996); LA. REV. STAT. ANN. §40:1098.5 (West Supp. 1996) (Provider shall . . .); ME. REV. STAT. ANN. tit. 19 §902 (West 1996).
74. *E.g.,* COLO. REV. STAT. ANN. §25-1-801(D) (1989); OKLA. STAT. ANN. tit. 63 §2602 (West 1984).
75. ME. REV. STAT. ANN. tit. 19 §§902, 905.
76. ADOLESCENT HEALTH, *supra* note 5, at 133.
77. 42 C.F.R. §2.14(b) (1995).
78. 42 C.F.R. §2.14(c).
79. 42 U.S.C. §§ 300ff-61(a) and 300ff-63 (West 1995).
80. NOTE, AIDS: BALANCING THE PHYSICIAN'S DUTY TO WARN AND CONFIDENTIALITY CONCERNS, 38 Emory L. J. 279, 293 (1989).
81. *E.g.,* ARIZ. REV. STAT. ANN. §36-664 (1993); COLO. REV. STAT. ANN. §25-4-1404 (1989); GA. CODE ANN. §24-9-47 (1995); MASS GEN. L. CH. 111 §70F (1995); N.D. CENT. CODE §23-07-02.1 (Supp. 1995).
82. *Id.*
83. See pages 14-17.
84. 45 C.F.R. §5b.6 (1995).
85. 20 U.S.C. §§1232g - 1232i (1991), implementing regulations at 34 C.F.R. §§99.1-99.67 (1995).
86. 20 U.S.C. §1232g(a).
87. 20 U.S.C. §1232g(b).
88. *E.g.,* CAL. EDUC. CODE §§49060 - 49079 (West Supp. 1996) ("It is the intent of the Legislator to resolve potential conflicts [in the law] regarding parental access to, and confidentiality of, pupil records in order to insure the continuance of federal educational funds.").
89. CONN. GEN. STAT. ANN. §10-15B(A) (West 1996).
90. E.g., CAL. EDUC. CODE §49060 (WEST SUPP. 1996) et seq.; GA. CODE ANN. §20-2-720 (1996).
91. CONN. GEN. STAT. ANN. §10-206(a) (West 1996).
92. CT St. §10-206(b).
93. 22 AM. JUR. 2D Damages §1 (1988).
94. In the absence of malpractice, there have been few, if any, reported cases in which a health care provider has been held liable in treating a mature minor solely based on failure to obtain parental consent. ANGELA RODDEY HOLDER, LEGAL ISSUES IN PEDIATRIC AND ADOLESCENT MEDICINE 133 (2d ed. 1985). A comprehensive discussion of medical malpractice claims is beyond the scope of this Guide.
95. 42 AM. JUR. 2D *Injunctions* §1 (1969).
96. MICH. COMP. LAWS §388.1766 (1988).
97. *Id.*
98. ARK. CODE ANN. §6-18-703(b) (Michie 1993).
99. MISS. CODE ANN. §41-79-5(1993).
100. Howlett By and through Howlett v. Rose, 496 U.S. 356, 367 (1990).
101. For an overview of the doctrine of preemption, see LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW, §§6-26 to 6-29 (2d ed. 1988).

102. California Coastal Commission v. Granite Rock Co., 480 U.S. 572, 581 (1987) (quoting Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Commission, 461 U.S. 190, 203-204 (1983)).
103. *Id.*
104. TRIBE, CONSTITUTIONAL LAW § 6-26.
105. 42 C.F.R. §2.14 (1995).
106. *E.g.,* MISS. CODE ANN. §37-7-301 (1996) (establishing powers and duties of local school boards).
107. CAL. EDUC. CODE §35010 (West1993).
108. Renken v. Compton City School Dist., 24 Cal. Rptr. 347 (1962).
109. Tucker v. San Francisco Unified School Dist., 245 P.2d 597, 602 (1952).
110. 42 U.S.C. §§701-709 (West 1991 and Supp. 1996); 42 U.S.C. §1305 (West 1991).
111. 42 U.S.C. §§1396 - 1396v (West 1992 and Supp. 1996).
112. 42 U.S.C. §§300 - 300a-8 (West 1991 and Supp. 1996).
113. 42 U.S.C. §§300x - 300x-9b (West 1991 and Supp. 1996); 42 U.S.C. §§ 300x-51 - 300x-64 (West 1991 and Supp. 1996).
114. 42 U.S.C. §254c.
115. THE SUPPORT CENTER FOR SCHOOL-BASED AND SCHOOL-LINKED HEALTH CARE, A GUIDE TO SCHOOL-BASED AND SCHOOL-LINKED HEALTH CENTERS VOLUME III: POTENTIAL SOURCES OF FEDERAL SUPPORT FOR SCHOOL-BASED AND SCHOOL-LINKED HEALTH SERVICES, (Washington, DC: Advocates for Youth [formerly the CENTER FOR POPULATION OPTIONS], 1993).
116. THE SUPPORT CENTER FOR SCHOOL-BASED AND SCHOOL-LINKED HEALTH CARE, A GUIDE TO SCHOOL-BASED AND SCHOOL-LINKED HEALTH CENTERS VOLUME III: POTENTIAL SOURCES OF FEDERAL SUPPORT FOR SCHOOL-BASED AND SCHOOL-LINKED HEALTH SERVICES 5 (1993). [hereinafter SOURCES OF FEDERAL SUPPORT]
117. *Id.* at 6.
118. 42 U.S.C. §§300x-21 - 300x-64 (West 1991 and Supp. 1996).
119. SOURCES OF FEDERAL SUPPORT, *supra.* note 115, AT 10.
120. 42 U.S.C. §§1396 - 1396v (West 1992 and Supp. 1996).
121. SOURCES OF FEDERAL SUPPORT, *supra.* note 115, at 17. (For a detailed description of the various elements of the Medicaid program as they relate to SBHC/SLHC, see the discussion at pages 17-23 in SOURCES OF FEDERAL SUPPORT).
122. 42 U.S.C. §1396d(a)(4)(C) (West 1992) (requiring states to provide or pay for family planning services to individuals of childbearing age including minors who can be considered to be sexually active).
123. For a detailed discussion of Medicaid managed care, see DONNA LANGILL ET AL., MEDICAID MANAGED CARE: AN ADVOCATE'S GUIDE FOR PROTECTING CHILDREN (1996).
124. SOURCES OF FEDERAL SUPPORT, *supra.* note 115, AT 33.
125. SBHCS, supra note 21, AT 16. (citing, T.H. V. JONES, 425 F.SUPP. 873 (D.UTAH, 1975), aff'd 425 U.S. 986 (1976); *Doe v. Pickett,* 480 F.Supp. 1218 (D.W.Va. 1979).

126. 42 C.F.R. §51a.6 (1995).
127. 42 U.S.C. §300x-53(b).
128. 42 C.F.R. § 51c.110.
129. 42 C.F.R. § 59.15.
130. ARK. CODE ANN. §6-18-703 (Michie 1993).
131. §6-18-703(a)(1)(A).
132. §6-18-703(a)(2).
133. §6-18-703(b).
134. §6-18-703(c)(2).
135. §6-18-703(c)(1).
136. §6-18-703(a)(1)(A).
137. §6-18-703(a)(1)(B)(iii).
138. KY. REV. STAT. ANN. §156.497 (Michie Supp. 1994).
139. §156.497(4).
140. §156.497(4)(a)-(e).
141. §156.497(6).
142. §156.497(7)(i).
143. *Id.*
144. §156.497(6).
145. LA. REV. STAT. ANN. §40:31.3B(1) (West 1992).
146. §40:31.3B(3).
147. §40:31.3A.
148. §40:31.3C.
149. FLA. STAT. ANN. §402.321 (West 1993).
150. §402.321(1).
151. §402.321(4).
152. §402.321(4)(b).
153. MO. REV. STAT. §167.611 (Supp. 1996).
154. §167.611(2).
155. *Id.*
156. §167.611(3).
157. §167.611(4).