

Teenagers, Health Care & the Law

**A Guide to the
Law on Minors' Rights in New York State**

by

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Rebekah Diller, Jaemin Kim and Yueh-ru Chu



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Introduction

Adolescents, more than members of any other age group, often do not get the health care they need.¹ According to the American Medical Association, a major reason for this is that adolescents fear that health care providers will disclose confidential information about sensitive issues to their parents or guardians.² In fact, the law allows teenagers to obtain medical treatment—including “sensitive” health care, such as reproductive health care—without their parents’ involvement or even knowledge in a variety of situations.

This booklet seeks to clarify teenagers’ rights under New York and federal law to make their own medical decisions. It is designed as an aid to teenagers and the professionals—social workers, counselors, teachers and medical providers—who work with young people.

Frequently, professionals can encourage communication between young people and their parents, helping adolescents find needed support as they confront health issues. When teenagers cannot or will not speak to their parents, professionals can encourage them to seek the support of other adults—family members, friends, social workers or teachers—rather than face their health problems alone. By publicizing information about adolescents’ rights, however, we hope to encourage teens to seek medical care even when they cannot or will not confide in adult family members or friends. We also hope to encourage professionals to respect the rights

of adolescents and provide care when a minor does not seek adult involvement. After all, health care without adult involvement is preferable to no health care.

The booklet is set up as a reference guide to the situations young people often encounter when seeking health care.

Section I defines the basic terms used to describe adolescents' legal rights.

Section II explains the general rules about minors' rights to consent to health care, and who can consent when a minor can't, such as parents and guardians. **Section II** also discusses adolescents who are married, pregnant, parents, emancipated or "mature" and therefore may have the right to make all of their own health care decisions.

Section III outlines the general rules regarding confidentiality in medical care, and those situations where confidentiality may be compromised.

Where specific areas of health care are involved, adolescents often can make their own health care decisions. **Section IV** sets forth the types of care that capable adolescents can generally obtain without parental consent. This section clarifies a teen's rights to consent to treatment relating to pregnancy, STIs, HIV and AIDS, sexual assault, substance use and mental health.

Section V discusses the specific challenges faced by minors in foster care who seek confidential treatment.

Section VI provides an overview of public insurance programs available to minors.

At many points, a hypothetical question is offered to illustrate a scenario that might arise concerning a particular topic. We hope that the answers will further clarify the issues. The endnotes at the back of the book offer more detailed information and provide relevant legal citations.

This booklet, however, cannot take the place of individualized legal advice. A young person or provider may need to consult an attorney to address complex legal issues concerning health care.

We hope this booklet will assist in educating adolescents and providers about minors' rights, and that it will ultimately help young people to receive the health care they need and deserve.

I.

Basic Definitions

What is a Minor?

The law defines a minor as a person under the age of 18.³ A minor is denied certain rights under the law, such as the right to vote or run for elected office. However, a minor is also entitled to additional protection, such as financial support by a parent.⁴

Q

Today is Aisha's 18th birthday. Is she a minor?

A

No. She is no longer under the age of 18, so she is no longer a minor.

What is an Adult?

For the purposes of this booklet, "adult" refers to anyone 18 years of age or older.

What is Informed Consent?

"Informed consent," also referred to in this booklet as "consent," means that the patient voluntarily agrees to a proposed treatment. In order to

consent, the patient must have the *capacity to consent*, meaning he or she must understand:

- His or her condition; **and**
- The nature and purpose of the proposed and alternative treatments; **and**
- The predictable risks and benefits of the proposed and alternative treatments (including the option of no treatment at all).⁵

A patient who does not understand all of the above cannot give informed consent.

A health care provider must obtain informed consent before providing any medical treatment,⁶ unless it would not be reasonable to do so, as in many emergency situations.⁷ Consent can be given orally, through the use of a written form and sometimes can be inferred by a patient's conduct (for example, holding out an arm for a shot).⁸ A health care provider who fails to obtain consent before treating a patient may be liable for malpractice,⁹ negligence or assault and battery.¹⁰

When a person has the capacity to consent to a health service, that person also has the right to refuse to consent to a health service. This means that a person who understands his or her condition and the nature, risks and benefits of the proposed and alternative treatments cannot be forced to undergo such medical treatment.

Q

George is a mentally impaired adult. Can he consent to his own care?

A

Maybe. If the doctor reasonably determines that George understands his medical condition and the consequences of various treatments, George can consent to his own health care. However, no patient can give informed consent unless that patient understands the risks and benefits of the proposed and alternative treatments.

What is Confidentiality?

Confidentiality, with regard to medical treatment, means that information about the treatment, such as medical records, cannot be disclosed or released without the permission of the person who consented to the care.¹¹

Q

Sarah asks her doctor for a pregnancy test. Her boyfriend later calls the doctor to find out the results for her. Can the doctor disclose the results to Sarah's boyfriend?

A

No, not without Sarah's permission. The information is confidential and cannot be disclosed to anyone but Sarah.

II. Consenting to Medical Care

Minors and Consent

For the purposes of this booklet, when a minor “can consent,” “has the capacity to consent” or “can make his or her own health care decisions,” the consent of another person, such as the minor’s parent or guardian, is not needed. Under New York law, a minor who understands the risks and benefits of proposed and alternative treatments can consent to:

- Reproductive health care, including family planning (i.e., birth control and other contraception), emergency contraception, abortion, pregnancy/prenatal care, care during labor and delivery, and care for sexually transmitted infections;
- Certain mental health services;
- Certain alcohol and drug abuse services; and
- Sexual assault treatment.

Providers also can treat minors in an emergency without parental consent, but for other types of care minors must ordinarily obtain parental consent.¹²

In addition, the following categories of minors can consent to all, or almost all, of their own health care (*see pp. 19-23*):

- Pregnant and parenting teens;
- Married minors;
- Emancipated minors; **and**
- Minors serving in the armed forces.

Sometimes, mature minors also can consent to their own health care.

Providers should note that a minor’s ability to give informed consent is based on capacity for consent, as discussed above, not on age, and there is no minimum age requirement for giving informed consent. Some young minors may have the capacity for consent, while older minors may not. How capacity for consent was determined should be documented in a patient’s medical file.

When obtaining parental consent would interfere with a minor’s access to care that ordinarily would require parental consent, a health care provider often can treat the minor without parental consent. Health care providers can sometimes rely on the emergency care exemption (*see* p. 62) or the mature minor doctrine (*see* p. 22) to support the minor’s right to treatment without parental consent. Any determination concerning whether a minor has the capacity to consent to a health service should be documented in the minor’s medical records at the time the determination is made.

Q

Dana is 17. She goes to her doctor to be treated for genital herpes. Does the doctor need to get Dana’s parents’ permission before treating her?

A

No. A minor can consent to health care for sexually transmitted infections. Therefore, parental consent is not required.

Adults Who Can Consent on Behalf of a Minor

When a minor cannot consent to medical care (such as non-emergency treatment for acne or a cold, for example), he or she can only obtain services with the permission of another person, such as a parent or guardian, who can lawfully consent. The following adults may consent to the medical care of a minor.

Parents

Generally, parents have the right to make medical decisions for their minor children.¹³ A parent retains this right even when a court has determined the child to be a juvenile delinquent or a “person in need of supervision,”¹⁴ or when the parent has decided voluntarily to place the child in foster care.¹⁵ However, a parent whose child is voluntarily placed in foster care can delegate medical decision making authority to the local commissioner of social services.¹⁶

Guardians

When a minor has a legal guardian, the guardian may consent to the minor’s health care.¹⁷

The Commissioner of Social Services

If a Family Court judge determines that a child has been abused or neglected and takes the child into court custody, or if a child has been removed from his or her parents and placed in the local commissioner’s custody, the local commissioner of social services or the local commissioner of health may consent to health care for the child.¹⁸

Q

Patricia, 34, has decided that she cannot care for her 14-year-old son until she deals with her drinking problem. She places him in foster care. Her son needs to be treated for strep throat. Who consents to the boy's health care?

A

Even though he is in foster care, Patricia consents to her son's medical treatment. However, she could delegate the responsibility of consenting to his care to the local commissioner of social services.

Consent for Vaccinations

An adult caring for a child—a parent, legally appointed guardian, custodian, grandparent, adult sibling, adult aunt or uncle, or another adult who has written authorization to consent to the child's care—may consent to a child's vaccination,¹⁹ even if this adult would not necessarily be able to consent to other health care for the minor.

Q

Tom is six years old and needs a tetanus shot. His parents are out of town and he is staying with his aunt and uncle. Can they consent to the vaccination for him?

A

Yes. Even though they are only caring for him temporarily, they can consent to his vaccination.

Legal Status And Minors' Rights To Consent To Care

The law enables certain categories of minors to consent to all of their own health care. As with anyone seeking treatment, a minor who cannot adequately understand the risks and benefits of treatment cannot consent to care, regardless of legal status.

Married Minors

A married minor, like an adult, can make *all* of his or her own health care decisions, and the consent of another person (such as a parent or guardian) is not necessary.²⁰

Minors who are Parents

A minor who is a parent can also make *all* of his or her own health care decisions.²¹ Additionally, a minor parent can consent to all health services for his or her children.²²

Q

Rosa, who is sixteen, and her two-year-old son, Manuel, both catch the flu. Must Rosa involve her parents in order to get treatment at the doctor's office?

A

No. As a parent, Rosa can consent to all health care for herself and her child without a parent's involvement even though she is a minor.

Pregnant Minors

A minor who is pregnant can consent to all health services relating to prenatal care.²³ Virtually any medical, dental, health and hospital treatment that a pregnant woman receives can be regarded as "relating to prenatal care." For this reason, a pregnant teen can consent to all, or

almost all, health care services on her own behalf. (For information on special public health insurance programs available to pregnant women and minors, see pp. 67-71)

Q

Priti, who is fifteen and pregnant, falls and breaks her leg. Must a doctor get Priti's parents' consent in order to set her in a cast?

A

The doctor does not need Priti's parents' consent. Because a broken leg, if left untreated, would have medically adverse affects on her pregnancy, Priti's doctor could determine that treatment for the broken leg be considered prenatal care. Priti could therefore consent to the treatment without her parents' involvement.

Emancipated Minors

What is an Emancipated Minor?

Emancipation has been defined as the renunciation of parental rights to a child.²⁴ This means that parents can no longer make decisions for their child, and the child is entitled to some—but not all—adult rights and privileges, including the right to consent to one's own medical care and the right to retain one's own wages.

In New York State, no statutes clearly state how to determine whether a minor is emancipated and there is no clearly defined procedure for obtaining emancipated status. However, a minor in New York who is living as if emancipated is generally considered to be emancipated. If a minor is experiencing trouble exercising these rights, he or she can request a "letter of emancipation" from a youth legal services organization to show to a health care provider, school official or employer that explains that the

minor meets the legal criteria for emancipation and should therefore be accorded these rights.²⁵

Courts have only considered a minor to be emancipated if:

- He or she is married,²⁶ **or**
- He or she is in the armed services,²⁷ **or**
- He or she is economically independent through gainful employment,²⁸ **or**
- His or her parent has failed to fulfill parental support obligations *and* the minor seeks emancipation. *However, if the minor wishes to continue the parental-child relationship and receive support, the failure of the parent to provide support without just cause does not emancipate the minor.*²⁹

NOTE: Public assistance programs have their own criteria for determining when a minor is deemed the head his or her own household.

If a minor is emancipated, and cannot obtain necessary services in spite of a letter of emancipation, he or she should consider seeking more specific legal advice.

Can an Emancipated Minor Consent to Health Care?

Although few New York courts have spoken on whether emancipated minors may consent to their own health care, each court that has addressed this issue has found in favor of allowing emancipated minors to consent.³⁰

Q

Ron, 17, has been living on his own for two years. He is financially self-supporting and lives in his own apartment. He is not in regular communication with either of his parents. He needs to have his wisdom teeth pulled. Can the dentist perform the surgery without the consent of Ron's parents?

A

Yes. According to common New York practice, an emancipated minor can make all of his or her own health care decisions, and does not need parental consent.

If Ron were to have trouble obtaining services, he might seek the assistance of an organization that could grant him a letter of emancipation to further assure his health care provider of his emancipated status.

Mature Minors

In New York, a mature minor—a minor who is emotionally and intellectually mature enough to give informed consent and who lives under the supervision of a parent or guardian—may be allowed to make health care decisions without parental consent.

There is no formal process to be declared a mature minor; generally it may be done at the discretion of a health care provider.

In some states, a mature minor does not need to obtain parental consent in order to receive health care. Each state with such a doctrine establishes its own criteria, which may include the minor's age, medical condition, emotional and intellectual maturity, as well as the treatment's risks and necessity.³¹ Courts then decide on a case-by-case basis.³²

New York courts have never clearly defined the criteria for determining whether a minor is mature, or definitively established that a mature minor can obtain medical care without parental consent. In one case, however, an appellate court applied the mature minor doctrine in determining whether a 17-year-old could refuse life saving treatment on religious grounds. The court concluded that the boy was not a mature minor,³³ but the case indicates that a mature minor would be able to make medical decisions.

Further, the mature minor rule has been recognized by the medical ethics policies of many medical organizations, including the American Medical Association and the American Academy of Pediatrics.³⁴ These organizations urge providers to permit a minor with adequate decision-making capacity to consent to medical care and to notify parents only with the patient's consent. One reason cited is to avoid the risk that a minor will not receive needed care because he or she will not or cannot involve a parent.³⁵

Indeed, the New York State Bar Association has not “located a single reported case where a physician was held liable for providing medical treatment to a mature minor without parental consent.”³⁶

Q

Maria is a 17-year-old who suffers from severe allergies. She is fully capable of understanding her particular medical condition and the risks and benefits of various treatment options. She wishes to consult a physician, but because of their religious beliefs her parents have refused to grant her permission. Can she consent to her own health care?

A

Yes. Although the mature minor doctrine is not fully established in New York law, at least one court has recognized it. Since the mature minor doctrine is not prohibited in New York, medical ethics would permit a physician to treat a capable minor like Maria upon her informed consent. If her parents forbid the treatment, however, Maria might seek a court order stating that she is a mature minor and should be treated without parental consent.

Moreover, a physician who reasonably concluded that Maria's condition constituted an emergency requiring immediate attention could also treat her under the emergency exception to the parental consent requirement.

III.

Confidentiality in Medical Care

General Confidentiality Rules

Unless otherwise specified by law, a medical provider³⁷ may not reveal confidential information about a patient without the permission of the person who consented to the health care.³⁸ Violating this rule constitutes professional misconduct and may be punished by fine, reprimand or revocation of a license.³⁹ Additionally, a patient may sue a health care provider for damages for violating his or her confidentiality.⁴⁰ In certain narrow circumstances, the law may require or allow a health care provider to breach confidentiality and disclose information to specified person(s) or institution(s). However, even under these circumstances, other guarantees of privacy remain and general disclosure is not allowed.

NOTE: Medical confidentiality rules generally apply only to medical professionals and the individuals they supervise.⁴¹ These rules do not apply to people who obtain confidential medical information in non-professional capacities, such as friends, family members, neighbors and landlords.

Therefore, when a minor consents to health care, the information generally may not be disclosed to parents without a minor's permission.

When it is the parent, and not the minor, who consents to the minor's care, information about the treatment usually may be disclosed to the parent.

Sometimes, however, the law allows a health care provider to withhold information about a minor patient from the parent even when a parent consented to the initial treatment.

- A health care provider **must not reveal** the information to a patient's parents if he or she determines that disclosure would be detrimental to the provider's relationship with the minor, or to the minor's relationship with his or her parents.⁴²
- A provider **may withhold** information from a minor patient's parents if the minor is 13 or older and objects to the disclosure. In such cases, the health care provider can rely on his or her judgment as to whether to disclose the information.⁴³

Q A high school teacher is concerned that his student Robert is suffering from a health problem and is too scared to talk about it. Can the teacher look up Robert's medical records in the school-based clinic or call Robert's physician to find out what's wrong?

A No. That information is confidential. Without Robert's permission (if he consented to the care), or Robert's parents' permission (if the care was provided based on parental consent), Robert's health care provider cannot release his treatment information to the teacher.

The teacher can, however, encourage Robert to talk about his problem, meet with Robert's parents, or alert the health care provider to his concerns.

Schools and Confidentiality

State confidentiality laws apply to health services that are provided in school. Generally, parents consent to school-based health care. However, when an adolescent consents to health care in school, the medical records generally may not be disclosed without the student's permission⁴⁴ unless otherwise required by law (*see* pp. 30-34). In addition, counselors who operate in-school drug and alcohol programs that receive federal funds are bound by federal confidentiality requirements.⁴⁵

Other adults with whom a minor may interact at school—such as teachers, guidance counselors and coaches—are not necessarily required to keep conversations confidential. However, professional ethics and student privacy rights may prohibit school employees from disclosing to third parties highly person information about a student's pregnancy or sexual orientation.⁴⁶ As with other licensed health professionals, school health providers who reveal confidential information without permission may be subject to professional discipline and may also be sued for illegal disclosure.⁴⁷ If a student is uncertain whether a communication with a school staff member will be kept confidential, it is always safest to ask.

Phuong, a high school junior, complains to the school nurse that she has a sore throat and cannot eat. Phuong's parents signed a consent form at the beginning of the school year authorizing the nurse to treat Phuong. Can the nurse reveal this information to Phuong's parents? To the principal?

Q

The nurse could disclose the information to Phuong's parents because they are the ones who are entitled to consent to non-reproductive health care. However, the medical information should not be disclosed to the principal without Phuong's or her parents' consent.

In a counseling session with the school social worker, Jessi reveals that she is a lesbian. She asks the social worker not to tell anyone. Can the social worker "out" Jessi to her parents?

A

No. This is a confidential communication between a social worker and a client and cannot be disclosed without Jessi's permission.

These confidentiality rules and privacy rights only apply to the medical and treatment records kept by school health providers. Parents and school officials do have the right, however, to access official health records relating to enrollment without the consent of students under 18.⁴⁸ Therefore, school health providers should keep confidential health information, such as counseling session notes and prenatal care discussions, separate from general health information related to education, such as routine immunizations and screenings. A separate set of medical records—solely

in the possession of the health care provider and inaccessible to other persons—can include the protected information, such as confidential reproductive health care services.⁴⁹

Q

Diana, 16, gives her gym teacher a note requesting that she be excused from gym because she is pregnant. Is the teacher bound by confidentiality?

A

Maybe. Generally, teachers do not have the same confidentiality obligations as school-based health professionals. There is no law requiring the teacher to disclose Diana's pregnancy to her parents or school staff members, although the gym teacher may choose to disclose this information to Diana's parents or the school nurse. Depending on the circumstances, disclosure to others may violate professional ethics and/or the student's privacy rights.

Some school districts do not respect these confidentiality obligations. For example, some schools ask school nurses, psychologists and social workers to report a student's pregnancy to her parents and/or school officials. Such policies violate New York law, and these school-based health providers put themselves at risk of committing professional misconduct if they reveal students' confidential communications. A school-based health care professional asked to do this should consult with an attorney before disclosing any confidential information.

When Otherwise Confidential Care May Not be Confidential

In certain situations, a health care provider may not be able to keep information relating to a minor's care completely confidential. Sometimes, the law requires a health care provider to report patient information to a government agency,⁵⁰ and in other situations, a provider may be compelled to reveal a confidential communication in a legal proceeding.

This section identifies the situations where health care may not be entirely confidential. In talking about issues of confidentiality with any patient, medical ethics dictate that providers discuss possible legal limitations on the confidential nature of their relationship.⁵¹

Child Abuse Reporting

What is the Child Abuse Reporting Law?

New York's mandatory child abuse reporting law carves a narrow exception into a professional's duty of confidentiality to minor patients. This law requires all "mandatory reporters"—which include health care providers and school officials⁵²—to make a report to the State Central Register of Child Abuse and Maltreatment when they have a reasonable suspicion that a minor is abused or neglected by a parent, guardian, custodian (any person regularly found in the child's household),⁵³ or other person responsible for the child's care.⁵⁴ A report will trigger an investigation of the parent or other responsible person. The patient's or student's permission is not required.

A caregiver is guilty of abuse⁵⁵ or neglect⁵⁶ if he or she directly harms a child or acts in a way that allows⁵⁷ a child to be physically or emotionally harmed or sexually abused.

The child abuse reporting law does not automatically apply whenever a child is a victim of a crime. **The appropriateness of a child abuse report depends on whether the wrongdoer is legally responsible for the child's care.** Further, reports to the Central Register can only trigger an investigation of the minor's parent(s) or other custodian or caregiver. Child protective services agencies are not authorized to investigate crimes

committed against children by third parties who are not in a caregiving relationship with the minor.

NOTE: A separate law governs physical or sexual abuse that is committed against a student by a school employee or volunteer. School employees must report any allegations of such abuse to school authorities, but *not* to the Central Register.⁶⁰

Mandatory reporters cannot be sued for making a report in good faith.⁶¹ However, a reporter's potential criminal liability for a report that turns out to be false is unclear. Although New York Social Services Law immunizes good faith reporters from criminal liability,⁶² it is a misdemeanor if a person "[r]eports...an alleged occurrence...of child abuse or maltreatment which did not in fact occur or exist."⁶³ No court has addressed this contradiction; however, due process considerations would make difficult the prosecution of a good faith report that turned out to be unfounded.

A 2007 provision now requires the mandated reporter to personally report suspected child abuse to the State Central Register, and inform the director of his or her agency or institution. This is a change from previous law, which called for a medical staff member to first report to a designated agent for the agency or institution, who then was responsible for making the report.⁵⁸

Also, as of 2007, social service workers who are employed by, or who have contracts with, local social service districts to provide services to children and/or families are now also under an additional obligation to report child abuse or maltreatment if a third party comes to them in their official capacity and provides them with information that, if true, would render a child abused or maltreated. The law requires social service workers to take the information from the third party at face value, and not to make a judgment call about whether or not the information is true.⁵⁹

How Might The Reporting Law Present a Confidentiality Problem for Non-Abused Minors?

The language of the child abuse reporting law has made some health care providers uncertain as to whether they must make a report when they learn that a parent is aware of an underage patient's voluntary sexual

activity.

This is because the law provides that caregivers who allow a sexual offense to be committed against a child may be considered abusive or neglectful. According to New York criminal law, any minor age 16 or younger who engages in vaginal, oral or anal sex is a victim of “sexual misconduct,” even when the activity is voluntary.⁶⁴ Therefore, when a parent knows that his or her underage child is having sex and does nothing to stop it, the question arises as to whether he or she is “allowing” a sexual offense (sexual misconduct) to be committed against his or her child.⁶⁵

The courts that have addressed this issue have refused to require blanket reporting of the parents of every sexually active minor in New York.⁶⁶ Therefore, **it is not child abuse for a parent to know that a minor child has chosen to be sexually active and to do nothing to stop it.**⁶⁷ In fact, New York courts have limited parental responsibility for a third party’s sexual offense against a minor to situations where the parent failed to intervene in *forced* sexual relationships of which they had personal knowledge.⁶⁸ Of course, this does not apply where the teenager is having sexual relations with a family member, where the sex is forced or where there is evidence of abuse other than the mere fact of a teenager’s consensual sexual activity.

Minors, particularly younger ones, should therefore note that if they seek confidential health care for an injury, pregnancy or STI that is not the result of parental or caregiver abuse, they should make this fact clear to their provider in order to ensure that an erroneous report is not made and an investigation does not ensue.⁶⁹ When a mandatory reporter is certain that the circumstances from which the need for medical care arose do not conform to the legal definitions of child abuse or neglect, no report should be made.⁷⁰

Delia, who is 15 years old, is planning to make an appointment with a family planning clinic to check for STIs and receive contraceptive care. She is sexually active with her boyfriend, who is 21. Should Delia be concerned that the clinic might report her case to child protective services because she is technically a victim of the crime of sexual misconduct?

Q

The law is on the side of Delia’s care remaining confidential. Courts have determined that parents are not guilty of abuse merely for knowing that their adolescent is having consensual sexual relations. In addition, Delia’s boyfriend is not a proper subject of a child abuse report—only parents, custodians or guardians are.

Must Delia reveal her boyfriend’s name if her health care provider asks?

No. Delia can keep this information private.

What if a minor who is a few years younger than Delia seeks care related to sexual activity?

A

Depending on the particular minor’s maturity, the minor’s partner’s age and other circumstances of the sexual relationship, some providers may determine that a younger minor has been forced or coerced into a sexual relationship with an adult. In that case, a provider with a reasonable suspicion that a parent or legally responsible adult has allowed the sexual abuse to occur, and thus abused or neglected the child, is obligated to report the parent.

Sexually Transmitted Infection Reporting

Health care providers are obligated to report to county and/or state departments of health all cases of syphilis, chlamydia and gonorrhea. Positive HIV test results are also subject to reporting. For a detailed discussion of these laws and how they relate to patient confidentiality, see the discussions of STIs and HIV/AIDS in Section IV.

Prevention of “Harmful Acts” To Third Parties

Psychologists, psychiatrists **and rape crisis counselors** may breach confidentiality to notify an endangered person and/or the police if a patient presents a serious and imminent danger to that individual.⁷¹ However, notification is not mandatory.⁷²

Court Proceedings

As a general rule, health care providers cannot disclose confidential medical information without the patient’s consent. In legal proceedings, special laws that protect confidential communications create a rule known as the “doctor-patient” privilege⁷³ and apply to communications between a patient and a physician, registered professional nurse, licensed practical nurse, dentist, podiatrist or chiropractor;⁷⁴ psychologist;⁷⁵ social worker;⁷⁶ or rape crisis counselor.⁷⁷ However, even these providers may be compelled to testify in court or release confidential records in connection with child abuse or neglect proceedings⁷⁸ and when a patient under the age of 16 has been the victim of a crime.⁷⁹

NOTE: Although providers have an affirmative obligation to report reasonable suspicions of child abuse, there is no such obligation regarding other crimes committed against a minor patient with the exception of mandated reports of gunshot and **life-threatening** stab wounds (*see p. 57*). In fact, making a police report without the patient’s consent would violate confidentiality and constitute professional misconduct.⁸⁰

Confidentiality in the Insurance and Billing Process

Some insurance procedures and methods of payment or billing can compromise confidentiality. Problems can arise, for example, when bills for services are sent home.

In addition, a state law requiring managed care plans to notify the patient in writing and by phone regarding services that require preauthorization can result in unintended disclosure.⁸¹ Some insurance plans, including managed care plans (HMOs) operating under the state’s Child Health Plus program, require preauthorization for abortion. It is therefore essential that providers find out whether the relevant HMOs require preauthorization and discuss the possible consequences with the patient.

There is no perfect solution to the problem of confidentiality in the medical billing process, but to minimize the risk of involuntary disclosure to parents in the billing process, a provider can:

- Discuss insurance, medical and lab billing, and alternative forms of payment with the minor patient and inform the patient if the billing process may compromise confidentiality;
- Warn a patient when a health service being sought requires preauthorization and will trigger a determination notice by mail and telephone to the minor’s residence;
- Ask the minor patient for alternative contact information if the patient does not want to be contacted at home; new federal regulations mandate that health care providers honor reasonable requests to alter the manner in which the provider communicates with the patient,⁸² and require insurance companies to honor requests to send information to a different address if disclosure of the information could endanger the patient;⁸³
- Request that an insurance plan require prenotification instead of preauthorization for a procedure, thereby avoiding a mandatory determination notice;
- Educate the billing department about minors’ rights to confidentiality and be sensitive to the diagnosis and treatment stated on bills that are sent home; and

- Consult with legal counsel before releasing any medical records that might result in harm to the adolescent patient. (For a discussion on medical information that may be subpoenaed in a court proceeding, see Section III).

A minor receiving confidential care should be aware that billing may lead to inadvertent breaches of confidentiality and always should:

- Ask providers whether treatment bills, lab bills or other documents will be sent home;
- Discuss using an alternate contact address for the purposes of such documents;
- Ask about sliding pay scales and cash payments that may reduce insurance and other billing problems.

Q

Jose, who is 16, receives treatment for a sexually transmitted infection. Because of the type of treatment, he does not need parental consent. He decides to pay for the treatment by using his parents' insurance plan. Will information about his treatment be disclosed to his parents through the billing process?

A

Possibly. The health care provider cannot disclose the information to Jose's parents. However, there is a risk of limited disclosure through the insurance process. By asking the insurance company about its notification procedures, both patient and provider can identify and respond to any risks.

IV. Types of Care that Minors Can Receive Without Parental Consent

A minor can generally obtain health services without parental consent for:

- Reproductive health services, including birth control, emergency contraception, abortion, care for sexually transmitted infections and HIV/AIDS, pregnancy care, labor and delivery care, and rape crisis care;
- Certain mental health services;
- Substance abuse treatment; and
- Emergency care.⁸⁴

The following are the consent and confidentiality laws for each type of care.

Birth Control

Consent

A minor may obtain confidential contraceptive services and prescriptions without parental notification or consent. The federal constitutional right to privacy underlies a woman's right to receive confidential contraceptive services.⁸⁵ The United States Supreme Court has extended this privacy right in matters relating to the use of contraception to minors as well as adults.⁸⁶ For this reason, the government cannot restrict a minor's access to

contraception without a compelling reason.⁸⁷ New York has not imposed any such restrictions.

Moreover, when a minor's health care is publicly funded (for example, through Medicaid), his or her access to family planning services is further protected. In fact, two federal programs—Medicaid and Title X—require that family planning services and supplies be provided to all eligible recipients, including sexually active minors.⁸⁸

Even when a court places a minor in a Catholic foster care agency, the minor must be given access to reproductive health information and services, including contraception.⁸⁹

Confidentiality

A minor is entitled to confidential family planning services without parental involvement.⁹⁰

Furthermore, courts have repeatedly construed the confidentiality safeguards of the Medicaid and Title X statutes to prohibit parental consent or notification requirements for teenagers entitled to family planning services under these programs.⁹¹

Q

A 14-year-old girl, Carla, wants to get a prescription for the Pill. Does she need parental consent?

A

No. Prescription contraceptives, like all other forms of contraception, must be made available to minors without parental consent.

Exception: Sterilization

Even though sterilization is a form of birth control, the laws governing sterilization are much stricter than those applicable to other birth control services. This is because of the permanent nature of sterilization, and is designed to avoid past abuses that involved the government forcing sterilization upon women of color, poor women and disabled women.⁹² There is a moratorium on federal and state funding for the sterilization of anyone under 21 years old.⁹³ Further, in New York City, sterilizations may not be performed on anyone under 18 years of age, regardless of the funding source.⁹⁴

Emergency Contraception

Emergency contraception (EC), or the “morning after pill,” is a high dose birth control pill that prevents pregnancy if taken shortly after unprotected sexual intercourse. EC is contraception; it cannot interrupt an already existing pregnancy, and is not the same as a drug known as mifepristone (RU-486), which is taken to induce abortion during the first nine weeks of a pregnancy. EC has been found to be effective when taken up to 72 hours after unprotected sex, and some studies have found it effective up to 120 hours after unprotected sex,⁹⁵ although as a rule, the sooner EC is taken following unprotected sex, the more successful it is in preventing pregnancy.

The New York Departments of Health and Social Services have instructed hospital emergency rooms to offer EC to minor rape survivors within 72 hours of unprotected sex where medically appropriate.⁹⁶ Also, the Title X program requires that family planning clinics receiving federal funding offer EC on the same basis as any other safe and effective family planning method.⁹⁷

Purchasing Emergency Contraception

In 2013, the FDA approved emergency contraception for sale without age restrictions. Minors can obtain emergency contraception in pharmacies without a prescription. For the most up to date information, please call

the NYCLU or the National EC Hotline (1-888-NOT-2-LATE), or visit www.not-2-late.com.

Emergency Contraception and Medicaid

Both over-the-counter and prescription EC are covered by New York State Medicaid. Medicaid clients do not need to present a fiscal note or any documentation from a doctor to use Medicaid to purchase emergency contraception from a pharmacist.

Emergency Contraception and Rape Crisis Care

New York State Public Health Law requires that every hospital providing emergency treatment to a survivor of sexual assault must promptly provide written and oral information about emergency contraception, and must also provide the emergency contraception when requested.⁹⁹

Consent

Because EC is a method of contraception, it is available to all minors without the consent of a parent.

Confidentiality

Because minors have the right to consent to contraceptive services, information relating to EC may not be disclosed without the permission of the patient.

Abortion

Various methods of **surgical abortion** are available depending upon the stage of pregnancy, the patient's preferences and other medical indications. Most surgical abortion procedures, which involve the use of surgical

instruments to remove the contents of the uterus, take only 10-20 minutes and are safer than getting a penicillin shot.¹⁰⁰

An early abortion also can be performed through the administration of medication instead of surgery. **Medical abortion** involves the use of drugs to cause the uterus to expel its contents, and at least two doctor's visits—first to get the medication prescription and to take the first pill, and second to ensure that the abortion is complete. The process can take between one day and several weeks, depending upon which medication is used.

Your provider can help you decide which method of abortion is best for you.

Consent

A minor in New York can obtain an abortion without parental involvement. While the United States Supreme Court has ruled that a state may require parental involvement in a minor's abortion decision, **New York State does not require parental consent or notification in order for a minor to have an abortion.**¹⁰¹ Therefore, a pregnant teen in New York may consent to (or refuse) an abortion, as long as she understands the risks and benefits of the procedure and its alternatives.

Confidentiality

New York law expressly forbids the release of medical records pertaining to a minor's abortion to the minor's parents without explicit consent from the minor.¹⁰²

As a matter of practice, most providers encourage teenagers to involve their parents or other supportive adults in their abortion decisions. Most teens do voluntarily consult one or both parents about their abortion decisions,¹⁰³ and those who do not often have compelling reasons, including, among others, a reasonable fear of abuse or of exacerbating already strained family situations.¹⁰⁴

Q

Kim is 15. She is from Iowa, but is staying in New York for the summer for a dance program. She has found out that she is pregnant, and wants to terminate the pregnancy. Does she need parental consent?

A

No. While Kim is in New York, she will be treated according to New York law. She does not need parental consent.

Sexually Transmitted Infections (STIs)

Consent

A minor may be tested or treated for a sexually transmitted infection (STI) without a parent or guardian's consent as long as the minor can give informed consent (he or she understands the risks and benefits of the proposed and alternative treatments).¹⁰⁵

Q

Tanya is 15. She thinks she might have herpes, but she doesn't want to tell her parents. Can she get medical attention without telling them?

A

Yes. Whether it's a diagnosis, prescription, or surgical treatment, physicians may treat adolescents for STIs without parental consent.

Confidentiality

New York law expressly forbids the release of information about STIs to parents or guardians without the patient's permission.¹⁰⁶

Health care providers, however, must comply with New York regulations that require them to report suspected or confirmed cases of communicable diseases. Because New York includes syphilis, chlamydia and gonorrhea in its list of communicable diseases, physicians must report cases of these STIs to state health officials.¹⁰⁷ The reporting requirements allow for limited disclosure of personal information only to the specified state officials, with high priority given to maintaining patient confidentiality, and so should not deter a minor from seeking testing and treatment for STIs. Public health officials must keep information regarding these cases confidential, except that very limited disclosure may be permitted to other public health agencies for purposes of disease control.¹⁰⁸

HPV

In 2007, the FDA approved Gardasil, a vaccine developed to protect women against common strains of HPV, a virus that is linked to both cervical cancer and genital warts. The vaccine has been approved for use in males and females age 9-26, and is available through the vaccines for children program.

Consent

The best course for providers administering the HPV vaccine, as with any medical treatment, is to attempt to obtain a minor's permission to involve a parent in the immunization decision. If parental involvement is not possible, it is the NYCLU's position that New York law supports the provision of the vaccine without parental consent.¹⁰⁹

However, the New York State Department of Health initially disagreed with that interpretation. While DOH is no longer affirmatively advising providers that parental consent is necessary, it has refused requests to issue further clarification of the law in this area. Because of this uncertainty, adolescent health care providers should seek the advice of legal counsel when setting their policies or addressing particular cases in this area.

HIV/AIDS

The law differentiates HIV/AIDS from other STIs and provides special protections for the confidentiality of people living with HIV or AIDS. But there are narrow exceptions in the law that require disclosure of HIV information under limited conditions (*see below*).¹¹⁰

Consent

A minor's ability to consent to HIV/AIDS care may vary depending on whether the minor seeks testing or treatment.

Testing

New York law requires written, informed consent before an HIV test can be administered.¹¹¹ Because the capacity to consent to such testing is determined without regard to age,¹¹² a minor has the right to consent to—or to refuse—HIV testing.

The law contains an exception to the written consent requirement for newborns, who are routinely tested at birth without parental consent, even though the test may not accurately reveal the baby's HIV status, and may

indicate whether the mother is HIV positive.¹¹³

When an individual decides to get an HIV test, he or she may choose to have either an **anonymous test** at a Department of Health site or a **confidential test**. The difference between the two types of tests is the degree of confidentiality associated with the results. **Anonymous** testing means that the person being tested does not reveal his or her name; informed consent is given through use of a coded system with no linking of individual identity to the test request or results. Therefore, the results can never be traced to the individual. Anonymous HIV/AIDS testing sites can be located by calling **the New York City Department of Health AIDS Hotline at 1-800-TALK-HIV** or by calling the regional offices listed on the New York State Department of Health web site (*see Important Resources*).¹¹⁴ All other HIV testing is **confidential** and means that while the results will largely be kept confidential, they will be subject to reporting and contact notification disclosures (*see below*).

Treatment

A minor's right to consent to treatment for HIV/AIDS is not as clear in the law as the right to decide about testing. However, some practitioners do allow minors with HIV/AIDS to consent to their own care when a minor is mature enough to give informed consent and comply with the treatment regimen, and where parental involvement is impossible or could cause harm.

Q

Raoul, a 16-year-old who lives with his mother, is HIV positive, but has not told his mother. Raoul has now developed an AIDS-related illness and wants medical care but will avoid treatment if he is required to tell his mother. His doctor believes he is mature enough to comply with the treatment regimen. Can the physician treat Raoul without parental consent?

A

Yes, the physician can treat Raoul without consulting either of his parents if she determines that Raoul understands his condition and the risks, benefits and treatment options, and if she determines that Raoul's health or well-being would be compromised by telling his parents. However, the physician may wish to help Raoul find a supportive adult in whom he can confide about his situation.

Confidentiality

Because people living with HIV/AIDS often face discrimination, confidential HIV-related information—meaning any information about whether a person has had an HIV-related test, has tested positive for HIV, or has an HIV-related illness or AIDS—generally may not be disclosed without the patient's permission. The law explicitly forbids physicians, health officers, social services providers and health care facilities from releasing confidential information, except in very limited circumstances, and only to designated individuals or facilities.¹¹⁵ In fact, any such person who discloses confidential HIV-related information without a signed release under circumstances other than those prescribed by law (see below) will be subject to civil and criminal penalties.¹¹⁶

Special Confidentiality Considerations in HIV/AIDS Care

Disclosure to a Minor's Parents or Guardians

Confidential HIV-related information can be disclosed to a minor's parents without permission **only if**:

- the health care provider determines that the minor is not able to consent to his or her own HIV-related care; **and**
- the physician reasonably believes that disclosure is medically necessary in order to provide timely care and treatment; **and**
- the physician has given the minor appropriate counseling regarding the need to disclose the information to the minor's parents and the minor still will not make the disclosure him or herself.¹¹⁷

Even if all the above conditions are met, a health care provider **may not disclose** confidential information to a minor's parents if:

- The provider believes that “the disclosure would not be in the best interest of” the minor,¹¹⁸ **or**
- The minor is otherwise authorized to consent to medical care by virtue of marriage, parenthood, pregnancy, or emancipation (See Section II).

All decisions regarding parental involvement in a minor's HIV/AIDS treatment, including the reason for the decision, must be recorded in the minor's medical records.¹¹⁹

Disclosure to a Minor's Foster Parent, Adoption or Foster Care Agency, or Law Guardian

While a minor in foster care has the same right to refuse or consent to an HIV test or treatment as any other minor,¹²⁰ information about such testing or treatment is sometimes subject to broader disclosure. Note, however, that as with any other patient, minors in foster care who receive an anonymous HIV test will be assured confidentiality.

When a minor in foster care is tested confidentially, but not anonymously, HIV-related information can be released to both of the following:

- An authorized foster care or adoption agency.¹²¹ Those agencies, in turn, **must release** information to prospective foster or adoptive parents.¹²²
- A law guardian appointed to represent the minor in court. If the minor is capable of consenting to his or her own health care, the law guardian cannot redisclose the information to anyone else without the minor's permission.¹²³

Disclosure Pursuant to Written Consent

A patient's general authorization for the release of medical information is **insufficient** to authorize disclosure of HIV information.¹²⁴ Rather, written consent must specify that HIV information is to be disclosed. Disclosure without specific written consent is punishable by a jail sentence or fine.¹²⁵

Disclosure Pursuant to a Court Order

Providers may be required by court order to disclose confidential HIV information to someone who would not otherwise have access.¹²⁶

However, the person requesting the court order must prove special circumstances to justify the exception, and the court must safeguard the confidentiality of the HIV-related information.¹²⁷

Initial Tests and Diagnoses of HIV: Reports to the Department of Health

Physicians and other designated medical personnel¹²⁸ must report to the New York State Commissioner of Health the names of individuals who receive an initial positive HIV test, an initial diagnosis of AIDS, or an initial diagnosis of an AIDS-related illness. In addition, under a new regulation, laboratories must divulge the results of other HIV-related tests, regardless of the patient's stage of treatment.¹²⁹ Note that this is a change from the previous rule, which only permitted reporting of the initial test result to the Commissioner. The state Department of Health cannot

disclose any of this information further, except to the extent necessary to conduct contact tracing.¹³⁰ (*See below.*)

Initial Tests and Diagnoses of HIV: Contact Tracing

A health provider is also required by law to report all known sexual and needle-sharing contacts¹³¹, upon an initial test or diagnosis. "Known contacts" may include a spouse, boyfriend or girlfriend, whether the name is disclosed by the patient or known independently by the provider.¹³² However, **the patient is not required to name any contacts**¹³³ and cannot be punished or denied treatment for refusing to do so.¹³⁴ Further, although the provider must ask the patient for contact names, he or she is not required to conduct independent research to identify additional contacts.¹³⁵

Local public health officials are responsible for notifying reported contacts that they may have been exposed to HIV. They decide whether a case merits contact notification in order to "protect the public health."¹³⁶

Public health officials responsible for notifying contacts may not disclose any information relating to the identity of the original HIV patient or any other contact.¹³⁷ However, a contact may be able to figure out independently who triggered the report and notification.

Although domestic violence screening is required, contact notification will only be deferred if, during the post-test counseling, the patient reports that notifying a particular contact would *severely* risk the physical health and safety of the patient, his or her children, or someone else.¹³⁸ Disclosure of domestic violence involving children can also lead to a child abuse investigation.

An individual always has the option of **anonymous** HIV testing. Individuals who are tested anonymously will not be reported. Anonymous testing ensures confidentiality because related information cannot be traced back to that person. However, reporting and contact notification rules are triggered once treatment begins.¹³⁹

Maya, who is fifteen, thinks that she might be HIV positive. She is worried that her boyfriend, Sean, who is seventeen and has a temper, might find out that she has cheated on him if he learns of her HIV status. What are Maya's options?

Maya can get tested for HIV at an anonymous HIV testing site. She will be given a coded receipt that she can use to get her results without anyone knowing her identity. If Maya tests positive, however, she cannot maintain complete anonymity once she begins treatment. Her treating doctor will perform a diagnostic test to confirm that Maya is indeed HIV positive, which will trigger the reporting and contact notification laws. Maya can choose not to share Sean's name with her doctor, or if her regular doctor already knows of Sean, Maya can choose to see a new doctor for treatment after receiving the anonymous test results. If Maya does tell her doctor about Sean or if she uses her regular doctor, contact notification could still be deferred if there is a severe risk that Sean will physically injure Maya or otherwise threaten her safety, although notification will be reconsidered at a later date.

Dr. Johnson has been treating Samuel, 17, for five years. With Samuel's informed consent, Dr. Johnson recently ordered an HIV test for Samuel that turned out positive. Dr. Johnson tells Samuel that she is required by law to ask about and report any sexual or needle-sharing partners that he may have, but that he is not required to share the names of such people. Samuel chooses not to tell Dr. Johnson of any contacts. What are Dr. Johnson's obligations to report?

Dr. Johnson must report Samuel and any contacts of Samuel's of which Dr. Johnson knows. For example, if Dr. Johnson knows Samuel recently got married, she must report his spouse. However, Dr. Johnson does not need to perform any additional or independent investigatory work (such as interviewing other people) in order for her to have made a good faith report to the Department of Health. Even without such extra efforts, Dr. Johnson has fulfilled her reporting duty and will not be penalized for failing to identify or locate additional contacts.

A

Ongoing HIV Treatment: Partner/Contact Notification

In addition to the notification requirements associated with initial tests and diagnoses, a physician has the option of breaching a patient's confidentiality to directly inform a known contact if he or she believes disclosure is medically appropriate and there is significant risk of infection to the contact.¹⁴⁰ However, prior to any disclosure, the physician must follow each of the following steps:

- Counsel the individual living with HIV of the need to notify the contact; **and**
- Counsel the individual living with HIV of her intent to make disclosure to the contact as well as the physician's responsibility to report the patient's name and the name of contacts to the Health Commissioner; **and**
- Give the individual living with HIV a chance to choose whether the disclosure will be made by the physician or a public health officer; **and**
- Screen for domestic violence to determine if deferment of notification is warranted.¹⁴¹

Q

James is 16 years old and living with HIV. In a routine physical, he tells his physician about having unprotected sex with Maria, whom the physician also treats. Must the physician tell Maria she is at risk of being exposed for HIV or report this contact to the Department of Health? May the physician tell Maria?

A

The contact reporting requirements are not triggered by this visit because it did not involve the initial HIV testing or diagnosis. The physician may breach confidentiality and tell Maria only if medically appropriate and if she faces a significant risk of infection. However, the physician is not required to do so and cannot be sued or otherwise held liable for failure to tell Maria.¹⁴² Even then, disclosure may only be made if the physician follows the mandated counseling protocol with James.

Prenatal Care, Labor, and Delivery Services

Consent

A pregnant minor may consent to medical, dental, health and hospital services relating to prenatal care.¹⁴³ Labor and delivery services are also within the scope of the services to which a pregnant minor can consent. Once a child is born the minor parents can consent to all medical care for themselves and for their child.¹⁴⁴

Q

Priya is pregnant and 15 years old. May she decide whether to have a cesarean section or a vaginal delivery?

A

Yes. Physicians may strongly encourage a young woman to seek a supportive adult's assistance when making a difficult decision such as this. Ultimately, however, if Priya understands the risks and benefits of the procedures, she can make the decision for herself.

Confidentiality

As with other medical services to which minors may consent, all information about prenatal care, labor and delivery services must remain confidential.

Sexual Assault Care

What is Sexual Assault?

A person is sexually assaulted when anyone (including a stranger, acquaintance, date, spouse or family member) engages in any type of sexual activity with that person without his or her consent. This can be through use of physical force, emotional coercion, threats or manipulation. Also, a person may be incapable of giving consent by reason of mental impairment or physical incapacity (being drunk or having passed out, for example). A sexual assault can be violent or non-violent, and it may or may not involve physical injuries.

What Does Sexual Assault Care Involve?

When a person is sexually assaulted, he or she may seek reproductive health services or treatment for injuries. Sexual assault services involve two components: medical care (such as testing and prophylactic treatment for HIV and STIs, pregnancy testing and counseling, emergency contraception,¹⁴⁵ rape crisis counseling and treatment of injuries)¹⁴⁶ and the evidence collection kit (the “rape kit,” which is used to collect evidence of the assault, such as semen, hair and blood samples, for later use if the survivor chooses to file criminal charges).¹⁴⁷ Generally, evidence collection is most effective within 72 hours of the assault, and before showering.

A survivor can choose to receive care and have evidence collected and then decide later whether or not to file charges; merely having the examination done should not take this decision out of the survivor’s hands.¹⁴⁸

Consent

A minor who survives a sexual assault can consent to sexual assault care.¹⁴⁹ This is because minors may consent to all of the confidential reproductive and other health services that comprise sexual assault treatment,¹⁵⁰ as well as rape crisis counseling¹⁵¹ and forensic evidence collection.¹⁵²

Providers cannot require parental consent or disclosure for other parts of the sexual assault services, such as treatment of related injuries.¹⁵³

Requiring parental consent for related services would violate laws protecting the confidentiality of certain aspects of sexual assault treatment, including essential family planning and STI services.¹⁵⁴ Therefore, capable minors may consent to and receive confidential care for all the medical care provided in the post-sexual assault visit. Similarly, no one may force a capable minor to submit to a sexual assault exam.¹⁵⁵

Q

Susan, 16, is brought into the emergency room by her very angry mother, who thinks that Susan is having sex with her 18-year-old boyfriend. The mother demands that the emergency room doctors or nurses perform a “rape kit” on her daughter to determine whether or not she is still a virgin. Must the providers perform the examination?

A

No. A minor who is capable of giving informed consent cannot be forced to submit to such an examination. Further, medical ethics might also preclude the performance of this “virginity test” that has no medical purpose or benefit. Therefore, unless Susan voluntarily consents, the exam cannot take place.¹⁵⁶ Medical guidelines require providers to interview the patient separately from the parent to make this determination.¹⁵⁷

Confidentiality

As with other treatments to which a minor can consent, sexual assault care treatment must remain confidential. A health care provider has no general duty to report crimes committed against a patient, and any such reporting, unless required by law (*see* pp. 30-34) constitutes a confidentiality breach. Like other sexual assault survivors, a minor who is capable of giving informed consent has the authority to direct whether a hospital (or health clinic) should collect and keep sexual offense evidence,¹⁵⁸ whether it should be turned over to the police¹⁵⁹ and whether to file a criminal complaint. However, because the police are not bound by confidentiality rules, if a minor chooses to file a police report, he or she may lose control over how and to whom the information is disclosed.

As discussed in Section III, confidentiality may be breached in whole or in part if the circumstances surrounding the assault suggest child abuse¹⁶⁰ or if a health care provider is forced to disclose the information pursuant to legal proceedings and the sexual assault survivor is under the age of 16.¹⁶¹ Confidentiality may be breached in cases of sexual assaults (or other crimes) that take place at certain treatment facilities where patients are receiving mental health care due to certain reporting obligations (see additional material on page 59).

Q

Tracy is 15 and seeks rape crisis treatment after being attacked by a stranger. Besides reproductive health care, such as STI prophylaxis and emergency contraception, she needs care for bruises and other injuries. She does not want to involve her parents, however. Can the hospital call her parents without her permission to obtain consent for these other injuries? Can they report the assault to the police?

A

No. The hospital would compromise the confidentiality of the array of reproductive health care that Tracy can consent to if they notified her parents or the police about her other injuries. The hospital should counsel her and encourage her to notify a responsible adult, if any, who can assist her. However, if she has capacity to consent, they must honor her decision to keep the information confidential. Unless the assault involved a gunshot or stab wound, the hospital cannot breach her confidentiality and file a police report.

Confidentiality also may be breached in part if the assault involved a gunshot or **life-threatening** stabbing injury because such wounds must be reported to the police,¹⁶² or if the survivor tests positive for HIV, syphilis, chlamydia or gonorrhea, because such infections must be reported to the Department of Health.¹⁶³ However, these reports should not include any extraneous information, such as the reasons why the patient sought treatment, as such disclosures would violate confidentiality.¹⁶⁴

Mental Health Counseling and Services

Consent

A minor's right to receive mental health treatment without a parent's consent depends on the type of treatment sought: outpatient treatment, where a minor is living at home and visits the mental health care provider for treatment only, or inpatient treatment, where a minor resides in the hospital or mental health care center.

Outpatient Treatment

A minor who knowingly and voluntarily seeks mental health services can access treatment, including medication, without parental consent if any one of the following conditions applies:

- A parent or guardian is not reasonably available to consent; **or**
- Parental involvement would be detrimental to the course of treatment; **or**
- The parent or guardian has refused to give consent and a physician determines that treatment is necessary and in the best interest of the minor;¹⁶⁵

If none of these circumstances apply, New York law requires the consent of a parent or guardian for outpatient mental health treatment.¹⁶⁶ A young person may meet with a mental health care provider without prior parental consent in order to determine whether the minor meets these

guidelines.¹⁶⁷ Any determination as to whether the above criteria are met should be documented in the minor's medical record.¹⁶⁸

Q

Qiao-ling is 15. She is severely depressed and wants mental health treatment. Her parents, however, refuse to allow it. The physician believes that she needs to be treated. Can the doctor treat Qiao-ling?

A

Yes—if Qiao-ling consents to the treatment.

Inpatient Treatment

A minor 16 or over can seek inpatient mental health treatment, including medication, on his or her own, but younger teens must obtain parental consent.¹⁶⁹

A minor who seeks admission to an inpatient mental health program is given special protections to ensure that the program is serving his or her best interests:

- The minor, like any other mental health patient, must be informed that legal counsel is available.¹⁷⁰
- Within three days of the minor's arrival, notice must be given to Mental Hygiene Legal Services regarding the minor's admission.¹⁷¹

Generally, a patient (minor or adult) who has chosen to enter a mental health facility may not be kept involuntarily. However, if the institution determines that there are reasonable grounds to believe that the patient presents a danger to him or herself or to others, the patient may be held for a maximum of 72 hours, during which time the facility must petition a court for involuntary commitment.¹⁷² The court hearing must be scheduled within 72 hours of the date that the facility requests the

involuntary commitment.¹⁷³ Only if the court concludes that the patient poses a real and present threat to him or herself or others may the patient be involuntarily detained.¹⁷⁴

As with all other medical services, in an emergency, psychiatric treatment and medication must be made available to a minor without parental consent.¹⁷⁵

Q

Can Rahim, who is 15, consent to his own admission for inpatient mental health treatment?

A

No. A minor must be 16 or older to consent to inpatient mental health treatment.

Confidentiality

When a minor consents to mental health care, any information relating to treatment may not be disclosed without the minor's permission. Even when a parent gives consent, the parent is not guaranteed access to information relating to the treatment. When a parent requests access to a minor's mental health records, minors 13 and older may be notified of the request. If the minor objects to disclosure, the provider can choose to deny the parent's request.¹⁷⁶ Further, professional ethics generally dictate that specific details of therapy sessions not be disclosed without the consent of the patient.¹⁷⁷

Special Rules for Confidentiality in Mental Health Facilities

Although information relating to mental health treatment to which minors have consented on their own generally may not be disclosed without the minor's permission, there are some important exceptions to this general rule. In 2007, the NY Legislature passed a law known as "Jonathan's Law,"¹⁷⁸ which requires directors of certain residential

treatment facilities licensed by the State Office of Mental Retardation and Development Disabilities (OMRDD) to report incidents to parents that affect the health and safety of people receiving services, and allows parents and guardians to access facility records related to such incidents. A sexual assault that occurs at such a facility or under its auspices would trigger a report and render the records related to the incident available to parents.¹⁷⁹ Additionally, there are other provisions of the Mental Hygiene Law which allow for reporting to state officials and law enforcement authorities when a crime occurs either within certain types of mental health facility (which is not limited to residential facilities) or under the auspices of the facility.¹⁸⁰

Because of this new law and pre-existing law enforcement reporting obligations, confidentiality protections will vary from case to case depending on many factors, such as where the crime occurred and the type of facility in which the young person is receiving treatment. Health care providers are encouraged to seek legal counsel or to contact the NYCLU with questions about whether general confidentiality rules apply to a particular situation at a mental health care facility.

Alcohol and Substance Abuse Services

Consent

Although New York law generally mandates that steps be taken to involve parents in a minor's substance abuse treatment,¹⁸¹ a minor can receive non-medical alcohol or substance abuse services (such as counseling) without parental consent or notification.¹⁸² Further, a minor may receive inpatient or outpatient medical treatment for alcohol or substance abuse without parental involvement¹⁸³ if:

- The health care provider determines that the involvement of the parent or guardian would have a detrimental effect on the course of treatment; **or**
- the parent or guardian refuses to consent and a physician believes that treatment is necessary to the child's best interest;¹⁸⁴ **or**

- The minor is emancipated or is a parent.¹⁸⁵

Any decision to treat a minor without parental consent must be documented in the patient's record and must include a form, signed by the minor patient, indicating that he or she is voluntarily seeking treatment and has been advised of the availability of legal counsel.¹⁸⁶

Confidentiality

When a minor obtains alcohol or substance abuse services, the information must be kept confidential. When the services are obtained at a program or facility receiving federal substance abuse treatment funding, confidentiality is even more stringently protected.¹⁸⁷ In fact, when a patient receives any medical treatment at a drug and alcohol abuse and prevention facility—even if the treatment is unrelated to substance abuse—information relating to the treatment is confidential.¹⁸⁸ Such information cannot be used to initiate or substantiate criminal charges, or to conduct an investigation, against a patient.¹⁸⁹

Q

Jacob is 16. He is thinking about talking to a school substance abuse counselor about his drinking problem, but is scared that his parents will be notified. Can he receive counseling without parental consent?

A

Probably. Parental consent is generally not necessary for a minor to receive alcohol counseling, and most school-based substance abuse programs receive federal funding, which subjects them to strict consent and confidentiality rules. Whether or not the counselor decides to treat Jacob, the provider cannot disclose information to Jacob's parents without Jacob's permission.¹⁹⁰

Emergency Care

Consent

When an attempt to secure consent would delay treatment and increase the risk to the patient's life or health, a minor can receive medical, dental, health and hospital services without parental consent.¹⁹¹ One New York court stated that "if a physician or surgeon is confronted with an emergency which endangers the life or health of the patient, or [in which] suffering or pain may be alleviated, it is his duty to do that which the occasion demands...."¹⁹²

Q

Luis is 6. He is suffering from a severe asthma attack and a teacher takes him to the hospital. His parents cannot be found. Can he receive treatment?

Yes. The doctor can treat him because it is an emergency.

A

This time Luis broke his leg. Again, his parents are nowhere to be found. Can he be treated?

Yes again. While Luis might not die from waiting, a doctor can treat him under the emergency exception because his "pain may be alleviated" by prompt treatment.

Confidentiality

Generally, the person who did or who could have consented to the medical care has the right to keep it confidential. In the case of emergency care, parental consent is unnecessary because of medical expediency. If a minor's parents could be found quickly enough, though, their consent would be required. Therefore, upon a parent or guardian's request, information about a minor's "emergency [care] which was the result of accidental injury or the unexpected onset of serious illness" can be disclosed to the parent or guardian.¹⁹³

This rule is not absolute, however. A health care provider can use his or her discretion and choose to withhold medical information relating to a child's emergency care from a parent or guardian when the provider determines that disclosing the information to a caregiver would have a detrimental effect on the provider's professional relationship with the minor, the care and treatment of the minor, or the minor's relationship with his or her parent or guardian.¹⁹⁴

V.

Minors in Foster Care

A young person in foster care is entitled to consent to the same health care services as any other minor and is not required to notify anyone or obtain parental or foster care agency consent before seeking such health care. However, minors in foster care face greater risks that confidentiality of medical services will be compromised. This is because any medical information relating to a minor that is in the possession of a foster care or adoption agency must be released to prospective foster or adoptive parents when the minor is adopted or placed in foster care.¹⁹⁵

HIV-Related Information

Teens in foster care have far less confidentiality regarding HIV-related information than other minors. **Providers may** release “confidential” HIV-related information to an authorized foster care agency, without permission, but they are not required to do so.¹⁹⁶ **Foster care agencies,** however, **must** release any HIV-related medical information of which they have knowledge to prospective foster or adoptive parents,¹⁹⁷ but must safeguard this information from disclosure to others. Of course, if a minor receives anonymous HIV testing, results will remain confidential.

Reproductive Health Care

Teenagers are entitled to obtain health care through their foster care agencies.¹⁹⁸ This includes providing or arranging for confidential family planning services, such as contraceptive supplies and counseling, within 30 days of a request.¹⁹⁹ However, because medical information obtained by foster care agencies is subject to mandatory disclosure to any prospective foster or adoptive parents, in order to ensure full confidentiality, a teen could seek care for sensitive health issues from doctors or clinics that are independent from the foster care agency.

Q

Ragini, who is 16, is in foster care and wants to see a gynecologist to begin annual reproductive care check-ups. However, she does not want her foster care agency or foster parents to know about the private medical information that her doctor will learn about her. How can she keep the information confidential?

A

Ragini can seek treatment from an independent health care clinic or provider, such as Planned Parenthood or the Community Health Care Network, that is not associated with the foster care agency. They must keep her medical information confidential and cannot disclose it to foster care agencies. Note, however, that if Ragini sought HIV care, related information would be subject to disclosure, even if the health care provider is not affiliated with the foster care agency.

VI. Public Health Insurance Programs Available to Minors²⁰⁰

Medicaid

Medicaid is a publicly funded insurance program that covers comprehensive medical services, including abortion and birth control, for minors who meet income and immigration eligibility requirements. A list of community-based organizations that can help a young person apply for Medicaid or Child Health Plus (see below) may be obtained by calling 1-800-698-4KIDS (1-800-698-4543).

A fact sheet and FAQ entitled “Public Health Insurance Options and Reproductive Health for Teens in New York” created by the NYCLU can be accessed at www.nyclu.org/node/1335.

Eligibility

Generally, minors on Medicaid receive Medicaid services through a parent’s Medicaid budget. However, minors who live on their own or who are married, pregnant or parenting may apply on their own for Medicaid.²⁰¹

However, not all minors who can apply on their own will meet the income eligibility requirements for Medicaid, because sometimes parents’ income must be included in the eligibility calculation. Any minor living on his or her own, without parental support, can apply for Medicaid without parents’ income counting toward the income cut-off.²⁰² Further, any

pregnant minor—regardless of whether she lives with her parents or on her own—can also apply for Medicaid without having to use her parents’ income (for special services available to pregnant women on Medicaid, see **Medicaid/PCAP** discussion below).²⁰³ However, any other minor living at home, including married and parenting minors, must include their parents’ and spouse’s incomes in their household income to determine whether they are eligible to receive Medicaid.²⁰⁴

A newborn whose mother is on Medicaid is automatically covered by Medicaid through the first year of life²⁰⁵ and should be automatically enrolled. An infant should receive a Medicaid card within two weeks of birth, but until then the infant can receive health care services under the mother’s Medicaid card.²⁰⁶

Confidentiality

Medical services provided under Medicaid are subject to the same rules of confidentiality as are services provided under any other insurance plan, whether the minor is enrolled independently or under a parent’s Medicaid.

Confidentiality may be jeopardized when bills, lab reports or managed care statements (such as explanations of benefits, or preauthorization approvals) get sent home. The problem occurs most frequently with managed care plans. Providers and patients should check with their insurance plan about what the plan’s policy is regarding sending documents home. To guard against these kinds of confidentiality breaches, *minors who apply for Medicaid on their own may specify on the application a mailing address that is different from their home address (such as their health provider’s) so as to avoid confidentiality breaches through billing and other correspondence.*

Medicaid/Prenatal Care Assistance Program

The Prenatal Care Assistance Program (PCAP or PCAP/Medicaid) is a Medicaid program that offers pregnant women expanded Medicaid coverage for comprehensive health services related to a pregnancy.²⁰⁷ A pregnant woman or minor can apply for PCAP at a participating health

facility where she receives pregnancy-related care. A list of PCAP providers is available from the *New York State Growing Up Healthy* hotline at 1-800-522-5006.

Eligibility

PCAP/Medicaid offers services to pregnant women and minors whose income is higher than the regular Medicaid income limit and who are not otherwise eligible for medical assistance.²⁰⁸ A pregnant minor can obtain PCAP services as soon as she fills out the application at a participating PCAP facility or local Medicaid office, and does not need parental consent or authorization to enroll.²⁰⁹

Eligibility for PCAP/Medicaid is based solely on a woman’s income, unless she is married, in which case her spouse’s income also is considered.²¹⁰ Parental income is not considered, even when a pregnant minor is living with her parents.²¹¹

In addition, an applicant for PCAP/Medicaid is not required to provide information regarding her immigration status.²¹²

PCAP covers comprehensive prenatal services and all pregnancy-related care.²¹³ Additionally, because most pregnant minors would be eligible for regular Medicaid, they will also be covered for abortions.²¹⁴ Pregnant Medicaid patients can receive PCAP services for two months following the end of the pregnancy,²¹⁵ regardless of whether the pregnancy ends in a miscarriage, abortion, stillbirth or live birth.²¹⁶ These services include all clinical care that may be needed following the end of the pregnancy, as well as birth control. Further, newborns will be covered automatically by Medicaid for their first year of life.²¹⁷

Any pregnant woman, including an undocumented woman, who has Medicaid (including PCAP) during her pregnancy but who loses Medicaid after the pregnancy ends (for example, either because she is no longer eligible or because she fails to re-apply) will probably be eligible for 24 months of Medicaid-covered family planning services under the Family Planning Extension Program (FPEP).²¹⁸ FPEP is available regardless of whether the pregnancy ended in a miscarriage, live birth, stillbirth or

abortion.²¹⁹ However, in order to access FPEP services a minor must go back to the site where she received the pregnancy-related care.

Confidentiality

Under PCAP, pregnant minors are entitled to confidential medical services. In fact, providers are specifically instructed not to contact a pregnant minor's parents. Further, as with a regular Medicaid application, the PCAP application allows any applicant, including a minor applicant, to specify a mailing address (such as her doctor's office) that is different from her home address so as to avoid confidentiality breaches.

Q

Tiana is 15. She is pregnant and on PCAP. She and her doctor determine that she should have an ultrasound. Can her doctor inform her parents about the pregnancy or the procedure?

A

No. PCAP requires that the information be kept confidential.

Child Health Plus

New York's Child Health Plus (CHP) is a New York State publicly funded insurance program for children and adolescents age 18 and younger.²²⁰ CHP provides comprehensive health benefits including abortion and the full range of reproductive health care. A minor can get information on applying for CHP by calling 1-800-698-4543.

Eligibility

Because CHP has a higher household income limit than Medicaid²²¹ and is available regardless of an enrollee's immigration status,²²² there is a good chance that if a teen is not eligible for Medicaid, she or he will be eligible for CHP.

Generally, minors need parental participation in order to enroll in CHP. However, married and emancipated minors may enroll themselves in CHP, and teen parents may enroll themselves and their children in CHP without a parent or guardian's consent.²²³ Note that those who try to self-enroll must obtain the proper documents to verify household income eligibility.

Confidentiality

The medical services provided under CHP are subject to the same confidentiality rules as are all other medical services provided to minors. Billing may present a potential problem of confidentiality, however, because all CHP patients must choose a managed care plan, which may send home bills, explanations of benefits, preauthorization approvals and lab reports. For example, a New York law that requires managed care plans to notify a patient in writing and by phone when a service requiring preauthorization is sought (most surgical procedures require preauthorization) can result in such notices being sent home. Providers can work with their patients to find out whether their managed care plan sends home such documents and figure out how to avoid unintentional confidentiality breaches.

Conclusion

Health questions that minors face on a day-to-day basis are often extremely complex. Confusion about their rights can be compounded by their medical situation, their immigration status, their inability to pay for their own care or any number of other factors.

This booklet offers broad guidelines on minors' rights to confidential health care. The Reproductive Rights Project of the New York Civil Liberties Union hopes that this guide will raise awareness about minors' rights, thereby increasing the likelihood that minors will seek health care when they need it.

This guide, however, is by no means comprehensive and is not intended to provide individualized legal advice.

When a minor is faced with a difficult legal question relating to health care that is not addressed by this booklet, feel free to contact us directly at:

**Reproductive Rights Program
NEW YORK CIVIL LIBERTIES UNION**

125 Broad Street, 19th Floor
New York, NY 10004
Phone: (212) 607-3300
Fax: (212) 607-3318

We are also available to offer additional materials and present workshops for young people and youth services providers.

ENDNOTES

- 1 SUSAN G. MILLSTEIN, THE POTENTIAL OF SCHOOL-LINKED CENTERS TO PROMOTE ADOLESCENT HEALTH AND DEVELOPMENT 7 (Carnegie Council on Adolescent Development Working Paper, 1988).
- 2 Survey results published by the Journal of the American Medical Association indicate that if adolescents were told that they would have to inform their parents, only 15% would seek treatment for sexually transmitted diseases. If, instead, the teenagers were assured of confidentiality, 65% would seek care. Council on Scientific Affairs, American Medical Association, *Confidential Health Services for Adolescents*, 269 JAMA 1420 (1993).
- 3 N.Y. GEN. OBLIG. LAW § 1-202 (McKinney 2001); N.Y. C.P.L.R. § 105(j) (McKinney 2001).
- 4 In fact, children are entitled to child support from their parents until age 21 – even after they are legally adults – although this duty may be subject to the parent’s financial means. N.Y. FAM. CT. ACT § 413 (McKinney 2001); *People v. Hinton*, 40 N.Y.2d 345 (1976).
- 5 N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2001); N.Y. MENTAL HYG. LAW § 80.03(c) (McKinney 2001).
- 6 *See, e.g., Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Dunlop v. Sivaraman*, 709 N.Y.S.2d 419 (App. Div. 2d Dep’t 2000); *Lipsius v. White*, 458 N.Y.S.2d 928 (App. Div. 2d Dep’t 1983).
- 7 N.Y. PUB. HEALTH LAW § 2805-d(4)(c) (McKinney 2001).
- 8 COMMITTEE ON MEDICINE AND LAW, ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, THE MEDICAL TREATMENT OF MINORS UNDER NEW YORK LAW (reprinted by Planned Parenthood of New York City, n.d.).
- 9 In order to recover damages for malpractice based on lack of informed consent, a plaintiff must establish that (1) the provider failed to disclose treatment alternatives and reasonably foreseeable risks and benefits involved that a reasonable practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation, (2) a reasonably prudent person in the patient’s position would not have undergone the treatment or diagnosis if fully informed, and (3) the lack of informed consent was a proximate cause of the injury or condition for which recovery is sought. N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2001).
- 10 Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 1 (June 29, 2000).
- 11 Under New York law, communications with a health care provider are considered confidential when: (1) the relationship of provider and patient

- existed; (2) the information was obtained in the course of treatment; and (3) the information was necessary for treatment. See *Griffiths v. Metropolitan St. Ry. Co.*, 171 N.Y. 106, 111 (App. Div. 1st Dep't 1902). A doctor who discloses confidential communications without the prior consent of the patient is guilty of professional misconduct. 8 N.Y.C.R.R. §29.1(8) (2001) ("Unprofessional conduct...shall include...revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law."); N.Y. EDUC. LAW § 6509(9) (McKinney 2001) (declaring any unprofessional conduct to be professional misconduct). Limited statutory exceptions will abrogate the confidentiality rule, requiring or allowing disclosure of otherwise confidential communications. See pp. 30-34. Unless otherwise required by law, a health care provider who commits professional misconduct by disclosing confidential information may be subject to professional and legal sanctions. For a full discussion of a provider's duty of confidentiality and the consequences of breaching this duty, see Section III.
- 12 Generally, minors may only receive medical treatment with the consent of their parents or custodians. See *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941) ("[T]he general rule is that the consent of the parent is necessary for an operation on a child."); *Alfonso v. Fernandez*, 606 N.Y.S.2d 259, 262 (App. Div. 2d Dep't 1993) (recognizing the common law rule requiring parental consent for the provision of health services to a minor); *In re Rosebush*, 491 N.W.2d 633, 683 (Mich. App., 1992) ("It is well established that parents speak for their minor children in matters of medical treatment.").
- 13 See *supra* note 12.
- 14 A "person in need of supervision" (PINS) is "[a] person less than eighteen years of age" who is an habitual truant (i.e., has unexcused absences from school) or who is incorrigible, ungovernable or habitually disobedient and beyond the lawful control of parent or other lawful authority or who [unlawfully possesses marijuana]." N.Y. FAM. CT. ACT § 712(a) (McKinney 2001); N.Y. EDUC. LAW § 3205 (requiring minors from age six to age 16 to attend full time school instruction).
- 15 Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 9 (June 29, 2000).
- 16 *Id.*
- 17 See, e.g., *In the Matter of Storar*, 52 N.Y.2d 363, 380 (1981) (interpreting N.Y. PUB. HEALTH LAW § 2504(2) to authorize a "parent or guardian...to consent to medical treatment on behalf of an infant"); *T.D. v. New York State Office of Mental Health*, 650 N.Y.S.2d 173, 187 (App. Div. 1st Dep't 1996) (noting that informed consent for a minor must be obtained from a parent or legal guardian); N.Y. PUB. HEALTH LAW § 2442 (McKinney 2001) (requiring the consent of a parent or legal guardian in order to include a minor in research protocol).
- 18 N.Y. SOC. SERV. LAW § 383-b (McKinney 2001).
- 19 A caregiver other than a parent, guardian or custodian may not consent to a vaccination if that person has reason to believe that the parent, guardian or custodian would object to the child's vaccination, however. N.Y. PUB. HEALTH LAW § 2504(5) (McKinney 2001).
- 20 N.Y. PUB. HEALTH LAW § 2504(1) (McKinney 2001) ("[A] minor who...has married may give effective consent to medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary."). Because the law applies to a minor who "has married," a minor who is divorced should also be able to consent to his or her own care. As of yet, New York courts have not ruled on this issue.
- 21 N.Y. PUB. HEALTH LAW § 2504(1) (McKinney 2001).
- 22 N.Y. PUB. HEALTH LAW § 2504(2) (McKinney 2001).
- 23 N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 2001).
- 24 *Zuckerman v. Zuckerman*, 546 N.Y.S.2d 666, 668 (App. Div. 2d Dep't 1989); *Gittleman v. Gittleman*, 438 N.Y.S.2d 130, 132 (App. Div. 2d Dep't 1981). Emancipation is generally the product of an act or omission by a parent, not by the minor child, which expressly or impliedly evidences the intent to emancipate the child. Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 2 (June 29, 2000).
- 25 For example, in New York City, a youth services organization called The Door has a Legal Services Center that provides such letters for young people. Information is available at <http://www.door.org/programs/legal.html>, or see the back of this booklet for further contact information.
- 26 *Henry v. Boyd*, 473 N.Y.S.2d 892, 896 (4th Dep't 1984) ("[T]he marriage of a child under 21 years old renders the child no longer subject to the control and guidance of her parents, and on common law principles, she is emancipated and no longer legally required to accede to her parents demands, but is free to avoid their authority, no matter how reasonably exercised."); *Cochran v. Cochran*, 89 N.E. 470, 471 (N.Y. 1909); *Matter of Williams*, 431 N.Y.S.2d 334, 335 (Fam. Ct. Monroe Co. 1980); *Bach v. Long Island Jewish Hospital*, 267 N.Y.S.2d 289, 290-291 (Sup. Ct. Nassau Co. 1966). See also N.Y. Domestic Relations law § 84 (McKinney 2008) (terminating the general guardianship with respect to the person and not with respect to property when a person marries before he or she attains the age of majority).
- 27 *Zuckerman*, 546 N.Y.S.2d at 668; *Fauser v. Fauser*, 271 N.Y.S.2d 59, 61 (Fam. Ct. Nassau Co. 1966). Note that after the military service ends, "whether [the minor] continues his emancipation is solely within his control. He can continue this period of emancipation by remaining self-supporting and not submitting himself to the care and control of his parents. He may revert to his unemancipated status and be dependent on his parents for his support until he becomes re-emancipated or reaches his majority." *Id.* At 61. See also *Crimmins v. Crimmins*, 745 N.Y.S. 2d 686 (Ny Fam. Ct. 2002) (finding that although son's previous declaration of emancipation terminated former

- support obligation, the change of the son's circumstances required that there was still an obligation to provide support to a minor under the age of 21).
- 28 *Eason v. Eason*, 446 N.Y.S.2d 392 [App. Div. 2d Dep't 1982]; *Alice C. v. Bernard G.C.*, 602 N.Y.S.2d 623, 628 [App. Div. 2d Dep't 1993]; *Cellamare v. Lakeman* 829 N.Y.S.2d 588, 589 [N.Y.A.D. 2d Dep't 1997].
 - 29 *Gittleman v. Gittleman*, 438 N.Y.S.2d at 132.
 - 30 Married minors are the only emancipated minors who are given statutory authority to consent to their own health care. N.Y. PUB. HEALTH LAW § 2504(1) [McKinney 2001]. New York courts, however, have demonstrated support for the proposition that all emancipated minors may consent to their own health care. *See, e.g., Gittleman*, 438 N.Y.S.2d at 132 (defining emancipation as "the surrender of legal duties by a parent and the surrender of parental rights to a child," implying that the right to consent to medical treatment for the child – a parental right – becomes vested in the emancipated minor); *Bach*, 267 N.Y.S.2d at 291 (finding that a minor living independently from her parents had validly exercised a health care decision [although she was married, this case was decided prior to enactment of the law allowing married minors to consent to their own care and was not decided on this basis alone]); *Alfonso*, 606 N.Y.S.2d at 262 (recognizing the common law rule requiring parental consent for the provision of health services to a minor as subject to exceptions outlined by New York courts).
 - 31 LAW, YOUTH & CITIZENSHIP PROGRAM, NEW YORK STATE BAR ASSOCIATION/NEW YORK STATE EDUCATION DEPARTMENT, RIGHTS & RESPONSIBILITIES OF YOUNG PEOPLE IN NEW YORK: A LEGAL GUIDE FOR EDUCATORS AND HUMAN SERVICE PROVIDERS 88-89 [James M. Morrissey, ed., 3d ed., 1997].
 - 32 *See, e.g., In re Rena*, 705 N.E.2d 1155, 1157 [Mass. App. Ct. 1999]; *In re Rosebush*, 491 N.W.2d 633 [Mich. Ct. App. 1992]; *In re Swan*, 569 A.2d 1202 [Me. 1990]; *O.G., P.G., & M.G. v. Baum*, 790 S.W. 2d 839 [Tex. Ct. App. 1990]; *In re E.G.*, 515 N.E.2d 286, 288 [Ill. App. Ct. 1987]; *Cardwell v. Bechtol*, 724 S.W.2d 739 [Tenn. 1987].
 - 33 *In Re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 [Sup. Ct. Queens Co. 1990].
 - 34 COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CONFIDENTIAL CARE FOR MINORS, Ethics Opinion E-5.055 [1992] ("Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent."); American Academy of Pediatrics, *Policy Statement: Informed Consent, Parental Permission, and Assent in Pediatric Practice (RE9510)*, 95 PEDIATRICS 314 [1995] ("In cases involving emancipated or mature minors with adequate decision-making capacity, or when otherwise permitted by law, physicians should seek informed consent directly from patients."). *See also* Christine M. Hanisco, *Acknowledging the Hypocrisy: Granting Minors the Right to Choose Their Medical Treatment*, 16 N.Y.L. Sch. J. Hum. Rts. 899, 922 n. 179 [2000], [quoting NATIONAL ASSOC. OF CHILDREN'S HOSPITALS, PEDIATRIC BILL OF RIGHTS (1974) [Any minor "who is of sufficient intelligence to appreciate the nature and consequences of the proposed medical care and if such medical care is for his own benefit, may effectively consent to such medical care in doctor-patient confidentiality."]].
 - 35 *See* AMERICAN ACADEMY OF PEDIATRICS, CONFIDENTIALITY IN ADOLESCENT HEALTH CARE (RE9151) (1989) ["Ultimately, the health risks to the adolescent are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care."]. This comment recognizes that many minors are so embarrassed and sensitive about the behavior or incident that led to the need for health care, that their fear of parental disclosure would cause them to defer or avoid health care. *See also*, Carol A. Ford et al., *Foregone Healthcare Among Adolescents*, 282 JAMA 2227 [1999] (finding that more than one-third of adolescents forewent needed medical care, and that the "leading reason was that they did not want their parents to know"); CATHY SCHOEN ET AL., COMMONWEALTH FUND, PUB. No. 252, THE COMMONWEALTH FUND SURVEY OF THE HEALTH OF ADOLESCENT GIRLS (1997) (concluding that treatment for sensitive health topics, including sexuality, is associated with an even higher rate of treatment avoidance: nearly one-half of young women and more than one-third of young men who experienced physical or sexual abuse reported not having received needed care).
 - 36 LAW, YOUTH & CITIZENSHIP PROGRAM, NEW YORK STATE BAR ASSOCIATION/NEW YORK STATE EDUCATION DEPARTMENT, RIGHTS & RESPONSIBILITIES OF YOUNG PEOPLE IN NEW YORK: A LEGAL GUIDE FOR EDUCATORS AND HUMAN SERVICE PROVIDERS 88 [James M. Morrissey, ed., 3d ed., 1997].
 - 37 This confidentiality rule applies to the professions of: acupuncture, athletic training, audiology, certified dental assisting, chiropractic, dental hygiene, dentistry, dietetics/nutrition, licensed practical nursing, massage therapy, medicine, midwifery, occupational therapy, occupational therapy assistant, ophthalmic dispensing, optometry, pharmacy, physical therapist assistant, physical therapy, physician assistant, podiatry, psychology, registered professional nursing, respiratory therapy, respiratory therapy technician, social work, specialist assistant and speech-language pathology. 8 N.Y.C.R.R. § 29.2 [2001].
 - 38 Revealing personal information obtained in a professional capacity without the prior consent of the patient constitutes unprofessional conduct. 8 N.Y.C.R.R. § 29.1 [2001]. Further, the Hospital Patients' Bill of Rights requires confidentiality of all information and records regarding care. 10 N.Y.C.R.R. § 405.7(c)(13) [2001].
 - 39 Any unprofessional conduct (*see* 8 N.Y.C.R.R. § 29.1 [2001]) is professional misconduct. N.Y. EDUC. LAW §§ 6509(9), 6511 [McKinney 2001].
 - 40 *See, e.g., Anderson v. Strong Memorial Hosp.*, 531 N.Y.S.2d 735, 739 [Sup. Ct. Monroe Co. 1988]; *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 802 [App. Div. 4th Dep't 1982].
 - 41 This includes employees who act in concert with or as agents of the health care professional such as receptionists. *See* *Desai v. Blue Shield*

- of Northeastern N.Y., 540 N.Y.S.2d 569, 571 (Sup. Ct. Albany Co. 1989). Confidentiality rules apply to other types of persons in certain situations. For example, social services workers are among those forbidden to disclose confidential HIV-related information, *see* Section IV.
- 42 N.Y. PUB. HEALTH LAW § 18(2)(c) (McKinney 2001).
- 43 *Id.*
- 44 As in other contexts, disclosure is not authorized without permission from the person who consented to the care, unless otherwise specified by law. *See* Section III.
- 45 **See infra note 44 and accompanying text.**
- 46 The concept of personal liberty grounded in the Due Process Clause of the Fourteenth Amendment of the United States Constitution creates a federal right of privacy against the public disclosure of an individual's private affairs by the government. *Whalen v. Roe*, 429 U.S. 589, 599 & n. 25 (1977), citing *Roe v. Wade*, 410 U.S. 113, 152-153 (1973). *See, e.g., Sterling v. Minersville*, 232 F.3d 190, 196, 197 (3d Cir. 2000) (holding that the disclosure of an individual's sexual orientation by a police officer would be a violation of that individual's constitutional privacy right where there is no "genuine, legitimate, and compelling" governmental interest in disclosure, and noting the unlikely probability of the government ever having such an interest regarding disclosure of an individual's sexuality); *Gruenke v. Seip*, 225 F.3d 290, 302-04 (3d Cir. 2000) (finding that public school gym teacher who compelled student to take a pregnancy test and failed to keep the test confidential violated the student's Fourteenth Amendment privacy rights).
- 47 N.Y. EDUC. LAW §§ 6509-6511 (McKinney 2001); *Anderson*, 531 N.Y.S.2d at 739; *MacDonald*, 446 N.Y.S.2d at 802.
- 48 *See* Federal Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C.A. § 1232g (2001) (denying funds to schools that refuse to allow parents of students under age 18 access to records and files that contain information about a student and are kept by a school or a school employee on behalf of the school).
- 49 *See* FERPA, 20 U.S.C.A. § 1232g(a)(4)(B)(i) (excluding records kept by school personnel that are in the sole possession of the maker and are not accessible or revealed to any other person except a substitute from the category of "education records" subject to parental disclosure); *see also* Mary Gelfman & Nadine Schwab, *School Health Services and Educational Records: Conflicts in the Law*, 64 ED. LAW REP. 319, 335-36 (1991) (recommending that conflicts between FERPA's requirement of parental disclosure and state confidentiality laws be reconciled by keeping records of confidential health information separate from educational records that are available to parents).
- 50 In addition to duties to report discussed in this section, New York laws and regulations also mandate reports of contagious disease, N.Y. PUB. HEALTH LAW § 2101 (McKinney 2001); vital statistics, N.Y. PUB. HEALTH LAW, Article 41 (McKinney 2001); bites by rabid animals, 10 N.Y.C.R.R. § 2.14 (2001); congenital malformations, N.Y. PUB. HEALTH LAW § 2733 (McKinney 2001); lead poisoning, N.Y. PUB. HEALTH LAW § 1370-a(c) (McKinney 2001); pesticide poisoning, 10 N.Y.C.R.R. §§ 22.11-.12 (2001); radiation illness and injury, 10 N.Y.C.R.R. § 16.9(c) (2001); and inflamed eyes within two weeks of birth, N.Y. PUB. HEALTH LAW § 2502 (McKinney 2001).
- 51 *See, e.g.,* American College of Obstetricians and Gynecologists, *Confidentiality in Adolescent Care*, 249 ACOG EDUCATIONAL BULLETIN 2 (1998).
- 52 The following professionals who work with young people are mandatory reporters: physicians (including surgeons, residents and interns) and registered physician assistants; registered nurses; emergency medical technicians; mental health professionals (including psychologists, substance abuse counselors and alcoholism counselors); other health professionals (including dentists and dental hygienists, podiatrists, osteopaths, optometrists, chiropractors and Christian Science practitioners); hospital personnel involved in patient admissions, examinations, care or treatment; school officials (including teachers, coaches, guidance counselors and principals); social services workers; employees or volunteers in certain residential care facilities; child care and foster care workers; law enforcement officials (including police officers, peace officers, district attorneys, assistant district attorneys and investigators employed by the district attorney's office). N.Y. SOC. SERV. LAW § 413(1) (McKinney 2001). Therefore, if any of these professionals, in the course of their official duties, gather information that creates a reasonable suspicion that a child is being harmed by a caregiver, he or she must report this suspicion to the State Central Register.
- 53 A custodian includes any person continually or regularly found in the same household as the child whose conduct causes or contributes to the abuse or neglect of the child. N.Y. SOC. SERV. LAW § 412(3) (McKinney 2001); N.Y. FAM. CT. ACT § 1012(g) (McKinney 2001).
- 54 N.Y. SOC. SERV. LAW § 413(1) (McKinney 2001). Any report filed pursuant to the child abuse reporting laws must be based upon a *reasonable* suspicion. One New York court held that reporting without making any preliminary inquiry as to the cause of an injury can constitute gross negligence, subjecting the reporter to civil penalties for false reporting. *See Vacchio v. St. Paul's United Methodist Nursery Sch.*, N.Y.L.J., July 21, 1995, p. 32, col. 2 (Sup. Ct. Nassau Co.) (finding that a teacher who reported a child's black eye to the State Central Register without first inquiring about the cause of the injury can be held liable for gross negligence); N.Y. SOC. SERV. LAW § 419 (McKinney 2001). Another court, however, clarified that a mandatory reporter who suspects abuse, but is not certain whether the surrounding circumstances fulfill the legal definition of abuse, should nonetheless file a report and allow the Register to make the legal determination. *Kimberly S.M. v. Bradford Cent. Sch.*, 649 N.Y.S.2d 588, 591 (App. Div. 4th Dep't 1996) (holding a teacher liable for failure to report child sexual abuse because she mistakenly thought the perpetrator, an uncle with whom the child spent vacations, was not a "person legally responsible," because the facts known to the teacher

- did create a “reasonable” suspicion of abuse).
- 55 N.Y. SOC. SERV. LAW § 412(1) (McKinney 2001); N.Y. FAM. CT. ACT § 1012(e) (McKinney 2001). Under these laws, a caregiver commits abuse if he or she (1) inflicts or allows the infliction of a non-accidental, physical injury that causes substantial risk of serious physical or emotional harm; **or** (2) creates or allows the creation of substantial risk of non-accidental physical injury that is likely to cause serious physical or emotional harm; **or** (3) commits or allows to be committed a sexual offense against the minor.
- 56 A parent, guardian, custodian or other person responsible for a minor’s care is guilty of child neglect when he or she fails to exercise care, thereby causing, allowing or creating a substantial risk of physical or emotional harm to the child. N.Y. SOC. SERV. LAW § 412(2) (McKinney 2001); N.Y. FAM. CT. ACT § 1012(f) (McKinney 2001).
- 57 The term “allows” in the context of child abuse and neglect is intended to address the parent or legal caregiver who knew or “should have known about the abuse and did nothing to prevent or stop it.” In the Matter of Katherine C., 471 N.Y.S.2d 216, 219 (Fam. Ct. Richmond Co. 1984) (finding a mother had neglected her daughter because she should have known that her daughter was being sexually abused by the stepfather and failed to act to protect her). See also Besharov, Practice Commentaries, McKinney’s Cons. Laws of N.Y., Book 29A, Family Ct. Act § 1012 at 314 (“Allowing” a child to be abused includes taking no appropriate protective (or preventive) action after being warned of the danger to a child.”). New York courts generally consider “whether a reasonable and prudent parent would have so acted (or failed to act) under circumstances then and there existing.” See, e.g., Katherine C., 471 N.Y.S.2d at 218.
- 58 N.Y. Soc. Serv. Law § 413.
- 59 N.Y. Soc. Serv. Law § 413(1)(b) (McKinney 2003). “Social service worker” is defined by New York State Office of Child and Family Services as professional or paraprofessional staff either employed by, or who have contracts with, local social service districts to provide services to children and/or families. 07-OCFS-ADM-15 (Dec. 13, 2007).
- 60 Under Article 23-B of the Education Law, any oral or written allegation of abuse by a school employee or volunteer made to a teacher, school nurse, school psychologist, school social worker, guidance counselor, school administrator, school board member or other school personnel required to hold a teaching or administrative license or certificate must be forwarded, in the form of a written report, to the school administrator. N.Y. EDUC. LAW § 1126 (McKinney 2001). Upon receipt of a report that gives rise to a reasonable suspicion that such abuse has occurred, the administrator must report such allegation to the child’s parent(s), to the school superintendent, and to “appropriate law enforcement authorities.” N.Y. EDUC. LAW § 1128 (McKinney 2001). Such authorities include the local police or sheriff, but *not* child protective services or other organizations for the prevention of cruelty to children. N.Y. EDUC. LAW § 1125 (7) (McKinney 2001). Any person who, in good faith, either makes or transmits such a report pursuant to Article 23-B is immunized from civil liability in any actions which may arise, N.Y. EDUC. LAW §§ 1126(3), 1128(4), and any person who willfully fails to submit a report to a school administrator or to appropriate law enforcement authorities will be guilty of a class A misdemeanor and may be civilly liable up to five thousand dollars. N.Y. EDUC. LAW § 1129 (McKinney 2001).
- 61 N.Y. SOC. SERV. LAW § 419 (McKinney 2001). Good faith is presumed unless the reporter acted with willful misconduct or gross negligence. Thus, a person who makes a report knowing that it is false (willful misconduct) or makes a report failing to exercise even slight care or diligence (gross negligence) is not immune from liability and may be sued for civil damages (e.g., damage to reputation) proximately caused by the false report.
- 62 N.Y. SOC. SERV. LAW § 419 (McKinney 2001).
- 63 N.Y. PENAL LAW § 240.50(4) (McKinney 2001).
- 64 N.Y. PENAL LAW § 130.20(1)-(2) (McKinney 2001) (defining sexual misconduct as engaging in sexual intercourse (meaning vaginal sex) or deviate sexual intercourse (meaning oral or anal sex) with another person “without such person’s consent”); N.Y. PENAL LAW § 130.05(2)(b) (McKinney 2001) (“Lack of consent results from...[i]ncapacity to consent.”); N.Y. PENAL LAW § 130.05(3) (a) (McKinney 2001) (“A person is deemed incapable of consent when he or she is...less than 17 years old.”). Other “statutory rape” sex crimes, which are deemed felonies and therefore carry a greater penalty, will apply when the minor is under a certain age and the minor’s partner is over a certain age, even when the sexual activity is consensual. The following rape laws apply only to vaginal intercourse: third degree rape occurs when the minor is 16 or younger and the partner is 21 or older (N.Y. PENAL LAW § 130.25(2) (McKinney 2001)); second degree rape occurs when the minor is 14 or younger and the partner is 18 or older, unless the age span between the two is less than four years (N.Y. PENAL LAW § 130.30(1) (McKinney 2001)); and first degree rape occurs when the minor is 12 and the partner is 18 or older, or when the minor is 11 or younger and the partner is any age (N.Y. PENAL LAW § 130.35(3)-(4) (McKinney 2001)). An additional set of sex crimes, with the same age differences corresponding to the same degrees, applies to oral and anal sex. (N.Y. PENAL LAW §§ 130.40(2), 130.45(1), 130.50(3)-(4) (McKinney 2001)). Another relevant sex crime is sexual abuse, characterized by “sexual contact”—meaning any touching of “intimate” parts. Third degree sexual abuse (a misdemeanor) occurs when the minor is 16 or younger and the partner is more than five years older (N.Y. PENAL LAW § 130.55 (McKinney 2001)); second degree sexual abuse (a misdemeanor) occurs when the minor is 13 or younger and the partner is any age (N.Y. PENAL LAW § 130.60 (McKinney 2001)); and first degree sexual abuse (a felony) occurs when the minor is 10 or younger and the partner is any age (N.Y. PENAL LAW § 130.65 (McKinney 2001)). The Legislature’s establishment of this age division was upheld as constitutional in *People v. Dozier*, 424 N.Y.S.2d 1010, 1014 (App. Div. 1st Dep’t 1980) (holding that even in the case of consensual sexual activity, these statutory sexual offense statutes serve state interests such as

- the prevention of teenage pregnancy and physical injury as well as immature decisions relating to forced marriages, parenthood, adoption, and abortion).
- 65 N.Y. FAM. CT. ACT § 1012 (e)(iii) (McKinney 2001) (defining “abused child” as a minor “whose parent or other person legally responsible for his care... allows to be committed an offense against such child defined in article one hundred thirty of the penal law”); N.Y. PENAL LAW §§ 130.05(2)(b), 130.05(3)(a), 130.20(1) (McKinney 2001) (making all minors under the age of seventeen who engage in vaginal, anal or oral sex victims of sexual misconduct, see *supra* note 64). Therefore, under a strict reading of relevant New York statutory law, a parent could be guilty of child abuse if he or she “allows” an underage child to be in a sexual relationship. New York courts, however, have not interpreted the statutory provisions to apply in such a case. See p. 32.
- 66 Holding parents criminally liable for a child’s sexual activity “fails to take into account the reality that the degree of supervision a parent is able to exert diminishes as a child’s freedom, independence, age and privacy increase.... Moreover, the imposition of legal liability presupposes that premature sexual activity occurs only in children whose parents do not teach proper moral values or offer role models consistent with that teaching, and fails, as well, to reflect an awareness that teenage pregnancies are the product of behaviors ranging from experimentation to outright defiance of parental authority.” In re Leslie C., 614 N.Y.S.2d 855, 861 [Fam. Ct. Kings Co. 1994]. According to the 1997 National Survey of Family Growth, approximately 40% of minors have sex before their seventeenth birthday nationally. NATIONAL CTR. FOR HEALTH STATISTICS, U.S. DEP’T OF HEALTH AND HUMAN SERV., PUB. NO. 19, FERTILITY, FAMILY PLANNING AND WOMEN’S HEALTH 23 (1997). Thus, a broad reading of the statutes that did not take into account the public policies outlined by the Leslie C. court would require that the parents of over 240,000 New York City minors be found guilty of child abuse or neglect, representing 40% the total 600,000 teenagers aged thirteen, fourteen, fifteen and sixteen in New York City. CITY HEALTH INFO., N.Y. CITY DEP’T OF HEALTH, SUMMARY OF REPORTABLE DISEASES AND CONDITIONS 17 (1996).
- 67 *Leslie C.*, 614 N.Y.S.2d 855 (dismissing charges of abuse and neglect against the mother of a sexually active fifteen-year-old girl). See also In re Philip M., 589 N.Y.S.2d 31 [App. Div. 1st Dep’t 1992], *aff’d*, 82 N.Y.2d 238 (1993) (noting that at trial, the court found that a 15-year-old with a sexually transmitted disease could not be presumed to be the victim of child abuse because the minor’s age indicated that he could have been engaged in “consensual sexual activity”); In the Matter of Toni D., 579 N.Y.S.2d 181 (N.Y. App. Div. 3d Dep’t 1992) (affirming the dismissal of a petition of abuse and neglect against the parents of a sexually active thirteen-year-old girl whose boyfriend was twenty-three).
- 68 *Leslie C.*, 614 N.Y.S.2d at 862.
- 69 Minors seeking confidential pregnancy, STI, or other reproductive health care are under no obligation to disclose the identity or relationship of their sexual partners. Merely noting that their partner is not a family member will suffice to alert a provider that the case before them does not qualify as child abuse or neglect.
- 70 In fact, where a report is made and the reporter is certain that the circumstances of the incident do not conform to the legal definition of child abuse, that reporter may be liable for civil damages and/or subject to criminal penalties.
- 71 N.Y. MENTAL HYG. LAW § 33.13(c)(6); **N.Y. C.P.L.R. § 4510(b)(2) (McKinney 2001)**.
- 72 No New York court has ruled directly on whether psychologists and psychiatrists should notify endangered individuals but some cases suggest that such a duty exists. One New York court has found a psychiatrist not liable for breaching a patient’s confidentiality to notify an endangered third party. Oringer v. Rotkin, 556 N.Y.S.2d 67, 68 [App. Div. 1st Dep’t 1990] (holding that psychologist’s records “document[ed] his finding that plaintiff presented a serious and imminent danger and authorized him to disclose the threat to the authorities and to the family of the boy”). Some courts have noted—although they have not ruled—that psychologists and psychiatrists should notify endangered individuals. See, e.g., Kolt v. United States, 1996 WL 607098, *2 (W.D.N.Y. 1996) (arguing that “confidentiality even in this area must yield to disclosure in the face of a stronger countervailing public interest such as where it becomes known to the psychiatrist-psychotherapist that the patient presents a particular risk or danger to others”); MacDonald v. Clinger, 446 N.Y.S.2d 801, 805 [App. Div. 4th Dep’t 1982] (holding that non-dangerous patient could bring action against psychiatrist who disclosed personal information learned during course of treatment to patient’s wife and noting that “where a patient may be a danger to himself or others, a physician is required to disclose to the extent necessary to protect a threatened interest”). Note, however, that these statements were made as part of the opinions’ *dicta* (the portion of a court opinion that discusses a point not necessarily arising from the facts of a case nor relied upon in making the ruling) and therefore *are not binding as legal precedent*. Therefore, although psychiatrists and psychologists may notify endangered individuals and will not be liable for civil damages if the court determines that concern for the endangered person was reasonable, there is as of yet no affirmative duty to report such individuals to the police or to endangered persons under New York law. No court has addressed whether other providers are similarly permitted to breach confidentiality under such circumstances. However, without ruling on this issue, the court in Ace v. State, 553 N.Y.S.2d 605 [Ct. Cl. 1990], indicated that “confidentiality must yield to disclosure in the face of a countervailing public interest such as where the patient is a danger to himself or others.” *Id.* at 607.
- 73 The privilege also exists between health maintenance organizations and patients and applies to hospital records. Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 13

- [June 29, 2000].
- 74 N.Y. C.P.L.R. § 4504(a) (McKinney 2001).
- 75 N.Y. C.P.L.R. § 4507 (McKinney 2001) [placing this privilege on the same basis as that between an attorney and her client].
- 76 N.Y. C.P.L.R. § 4508(a) (McKinney 2001).
- 77 N.Y. C.P.L.R. § 4510(b) (McKinney 2001). Privilege may be claimed only with respect to persons who have been certified by an approved rape crisis program as having satisfied New York State training standards (see N.Y. PUB. HEALTH LAW § 206(15) (McKinney 2001)) and who are working in an approved rape crisis program. Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 14 (June 29, 2000). The privilege extends to all employees working for the same program.
- 78 N.Y. FAM. CT. ACT § 1046(a)(vii) (McKinney 2001). For example, a psychologist may not claim privilege to avoid disclosing a communication from a teenager that suggests physical abuse by a caregiver.
- 79 N.Y. C.P.L.R. § 4504(b) (McKinney 2001); N.Y. C.P.L.R. § 4508(a)(3) (McKinney 2001). This exception only applies to physicians, registered professional nurses, licensed practical nurses, dentists, podiatrists, chiropractors and social workers, and not to psychologists or rape crisis counselors. In addition, in certain circumstances, a provider may be required to testify in proceedings where the confidential information relates to the use of controlled substances. However, the law does not clearly delineate when this exception should apply, and providers who are subpoenaed to testify under such circumstances should consult an attorney. *Compare* People v. Figueroa, 568 N.Y.S.2d 957, 959 (App. Div. 1st Dep’t 1991) (holding that when illicit drugs are recovered during surgery, physician-patient privilege is not applicable) *with* People v. Saaratu, 541 N.Y.S. 2d 889 (Sup. Ct., Bronx Co. 1989) (holding that the testimony of two doctors who operated on defendant and discovered balloons containing heroin in his stomach, and pathologist who took custody of balloons, was still subject to physician-patient privilege). Note that even if N.Y. PUB. HEALTH LAW § 3373 were interpreted to abrogate privilege in narcotics cases, it would not apply to patients who receive treatment in facilities receiving federal substance abuse treatment funding, which are subject to stringent confidentiality rules imposed by the federal government which preempt or supercede, the state law. See 42 U.S.C. § 290dd-2(a), (e) (2001).
- 80 8 N.Y.C.R.R. § 29.1 (2001); N.Y. EDUC. LAW § 6509(9) (McKinney 2001).
- 81 N.Y. PUB. HEALTH LAW § 4903 (McKinney 2001).
- 82 HIPAA, 45 C.F.R. § 164.522(b)(1)(i) (2001).
- 83 HIPAA, 45 C.F.R. § 164.522(b)(1)(ii) (2001).
- 84 In addition to these types of care to which a minor may consent without parental involvement, a minor who is 17 years old also will be eligible to donate blood without parental consent, N.Y. PUB. HEALTH LAW § 3123 (McKinney 2001).
- 85 Eisenstadt v. Baird, 405 U.S. 438, 443 (1972) (holding that a Massachusetts statute permitting married persons to obtain contraceptives to prevent pregnancy but prohibiting distribution of contraceptives to single persons for that purpose violated the Equal Protection Clause of the Fourteenth Amendment); Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965) (holding that a Connecticut statute prohibiting use of contraceptives by married persons unconstitutionally intruded upon the right of marital privacy).
- 86 Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 74 (1976) (“Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”); Carey v. Population Servs. Int’l, 431 U.S. 678, 693 (1977) (plurality opinion) (“[T]he right to privacy in connection with decisions affecting procreation extends to minors as well as to adults.”).
- 87 In *Carey*, 431 U.S. at 691-96, the Court flatly rejected the notion that the state could legitimately impede access to contraceptive services as a means of discouraging sexual activity. *Alfonso v. Fernandez*, 606 N.Y.S.2d 259 (App. Div. 2nd Dep’t 1993) does not change this rule. Its holding that a condom availability program in a public school’s Health Resources Center must contain a parental opt-out provision—thereby indirectly requiring parental consent—is limited to that narrow context. *Id.* at 260. The decision cannot be read to abrogate minors’ previously well-established rights under state law or the Constitution to consent to health care in other contexts.
- 88 Social Security Act Titles IV, XIX, XX; 42 U.S.C.A. §§ 300(a), 1396d(a)(4)(C) (2001) (“family planning services and supplies furnished [directly or under arrangements with others] to individuals of child-bearing age [including minors who can be considered to be sexually active] who are eligible under the State [Medicaid] plan and who desire such services and supplies”); 42 C.F.R. §§ 59.5(a) (“Each project supported under this part must...[p]rovide a broad range of acceptable and effective medically approved family planning methods [including natural family planning methods] and services [including infertility services and services for adolescents.”]), 440.240(b), 440.250(c) (2001) (“Family planning services and supplies must be limited to recipients of childbearing age, including minors who can be considered sexually active and who desire the services and supplies.”).
- 89 Wilder v. Bernstein, 645 F. Supp. 1292, 1306-07 (S.D.N.Y. 1986) (citing settlement stipulation requiring access to family planning information, services and counseling, in order satisfy Free Exercise Clause concerns), *aff’d*, 848 F.2d 1338 (2nd Cir. 1988); *Arneith v. Gross*, 699 F. Supp. 450 (S.D.N.Y. 1988) (“Minors have a constitutional privacy right to practice artificial contraception absent compelling state considerations to the contrary, and this is not diminished because they are in foster care.” (footnote omitted)).
- 90 *Carey*, 431 U.S. at 691-96; *Eisenstadt*, 405 U.S. 438; *Griswold*, 381 U.S. 479.
- 91 42 C.F.R. §§ 431.301, 431.305(b)(1)-(2) (2001). Further, cases considered by various federal courts have held that state statutes requiring parental

- consent for family planning services provided to otherwise eligible minors are preempted by the federal Medicaid statute, and that federal regulations requiring parental notification for similar services are preempted by Title X of the Public Health Service Act. *See, e.g., Jones v. T.H., 425 U.S. 986 (1976), aff'g mem. on statutory grounds, 425 F. Supp. 873 (D.Utah. 1975) [state statute]; Planned Parenthood Ass'n of Utah v. Dandoy, 810 F.2d 984 (10th Cir. 1987) [state statute]; Jane Does 1-4 v. State of Utah Dep't of Health, 776 F.2d 253 (10th Cir. 1985) [state statute]; New York v. Heckler, 719 F.2d 1191 (2d Cir. 1983) [federal regulation]; Planned Parenthood Fed. of America v. Heckler, 712 F.2d 650 (D.C. Cir. 1983) [federal regulation].*
- 92 Relf v. Weinberger, 372 F. Supp. 1196, 1199 (D.D.C. 1974); Relf v. Mathews, 403 F. Supp. 1235, 1238 (D.D.C. 1975).
- 93 42 C.F.R. § 50.203 (2001) [federal]; 18 N.Y.C.R.R. § 505.13(e)(1)(ii) (2001) [state].
- 94 New York City law defines the sterilization patient as “a person, twenty-one years of age or older, who is legally capable of giving his or her consent.” N.Y.C. CODE § 17-402(2) (2001). In order to be consistent with other laws providing that the age of consent is 18, the New York City Department of Health has interpreted this prohibition to apply to persons under 18 years of age. Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 6 (June 29, 2000).
- 95 Isabel Rodrigues et al., *Effectiveness of Emergency Contraceptive Pills Between 72 and 120 Hours After Unprotected Sexual Intercourse*, 84 AM. J. OBSTETRICS & GYNECOLOGY 531 (2001) [finding that emergency contraceptive pills have a favorable success rate after 72 hours, with a pregnancy rate that is significantly lower than would be expected if no contraceptive were administered]; P.W. Ashok et al., *Mifepristone as a Late Post-coital Contraceptive*, 16 HUMAN REPRODUCTION 72 (2001) [finding that the administration of mifepristone between 72 and 120 hours following unprotected sex prevented a pregnancy in 85% of 155 test subjects].
- 96 DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 49 (n.d.).
- 97 Memorandum Re: Emergency Contraception from Thomas Kring, Acting Deputy Assistant Secretary for Population Affairs, U.S. Department of Health and Human Services, to Regional Health Administrators (April 23, 1997) (on file with NYCLU).
- 98 Mike Mitka, *Promoting Emergency Contraception*, 285 JAMA 3080 (2001).
- 99 N.Y. Pub Health Law § 2805-p (McKinney 2008).
- 100 RACHEL BENSON GOLD, ALAN GUTTMACHER INSTITUTE, ABORTION AND WOMEN'S HEALTH: A TURNING POINT FOR AMERICA? (1990).
- 101 Planned Parenthood v. Casey, 505 U.S. 833, 899-900 (1992); Hodgson v. Minnesota, 497 U.S. 417, 458 (plurality opinion), [O'Connor, J., concurring] (1990); Planned Parenthood Ass'n, v. Ashcroft, 462 U.S. 476, 490-91 (1983); Akron v. Akron Ctr. for Reproductive Health, 462 U.S. 416, 439-40 (1983); Bellotti v. Baird, 443 U.S. 622, 643 (1979) (plurality opinion). In these cases, the United States Supreme Court ruled that parental consent requirements for abortion are unconstitutional unless they provide an expeditious and confidential judicial bypass procedure. New York has made no provision for such a bypass procedure. Therefore, although no New York statute explicitly allows minors to have an abortion, minors in New York may get abortions without parental consent.
- 102 N.Y. PUB. HEALTH LAW § 17 (McKinney 2001). In fact, anyone who unlawfully furnishes a report relating to a woman's referral for or inquiry regarding abortion services, or anyone who requests or obtains such documents under false pretenses is guilty of a Class A misdemeanor. N.Y. GEN. BUS. LAW § 394-e(4) (2001).
- 103 Based on a national survey of over 1,500 teenagers who had abortions and lived in states that do not mandate parental involvement (i.e., via consent or notification laws), 61% of teenagers aged 17 or younger had the abortion with the knowledge of at least one parent. Stanley K. Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 24 FAM. PLANNING PERSPS. 196, 197 (1992). Over 75% of these teenagers told their parents about the decision. *Id.* at 199-200. Further, 74% of those aged 15 and 90% of those aged 14 or younger involved a parent in the decision to have an abortion. *Id.* at 200. The most common reason given why minors involve a parent even though not required to do so is that they “wouldn't have felt right” not telling them. *Id.* at 202.
- 104 By way of example, 145,159 cases of child abuse and neglect were reported in New York State in 2000, of which 47,062 were substantiated. Letter from Joseph Conway, Assistant Counsel and Records Access Officer, New York State Office of Children and Family Services, to Anna Schissel, Law Fellow, New York Civil Liberties Union Reproductive Rights Project (September 18, 2001) (on file with NYCLU).
- 105 N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 2001).
- 106 N.Y. PUB. HEALTH LAW §§ 17 (“[R]ecords concerning the treatment of [a minor] for venereal disease...shall not be released [by a physician or hospital] or in any manner be made available to the parent or guardian of such [minor].”), 2306 (McKinney 2001).
- 107 10 N.Y.C.R.R. §§ 2.5, 2.10 (2001). Under § 2.10, physicians or persons in charge of a state licensed health facility must report the full name, age and address of every person with a suspected or confirmed case of a communicable disease to the New York City Department of Health (the City Department of Health will then forward demographic information to the New York State Department of Health and to the Centers for Disease Control, *see infra* note 105). However, 10 N.Y.C.R.R. § 2.10(b), which applies only to the STIs in the communicable disease category (syphilis, chlamydia and gonorrhea), offers greater anonymity for patients by allowing the reporting of the patient's initials in lieu of the patient's full name, although

- the provider must report the full name and address if the appropriate public health officer specifically requests it.
- 108 10 N.Y.C.R.R. § 2.32 (2001). For example, the New York City Department of Health maintains records of individuals who have been reported under 10 N.Y.C.R.R. § 2.10, *see supra* note 104, and will then compile relevant demographic information to report to the Centers for Disease Control and the New York State Department of Health. However, before so reporting, the New York City Department of Health removes all identifying information in order to uphold patient confidentiality. 10 N.Y.C.R.R. § 23.3 (2001), another reporting statute, requires county health clinics to maintain records of all patients diagnosed with and/or treated for STIs. The clinics must then send this information, in aggregate form only (i.e., with no identifying information linking the reports to a specific patient), to the New York State Department of Health. Telephone interview with Lynn Hoback, Field Operations Coordinator, Bureau of STD Control, New York State Department of Health (August 17, 2001).
- 109 *See* N.Y. Pub Health Law § 2305; *see also* discussion of “mature minors” doctrine, pages 12-13. For a full analysis of the legal basis for minors to consent on their own to provision of the HPV vaccine, *see* NYCLU Memorandum from Galen Sherwin, Director of NYCLU Reproductive Rights Project to Interested Parties re Parental Consent for HPV Vaccine, June 6, 2008, [available from NYCLU].
- 110 Disclosure of confidential HIV-related information is permitted in certain very limited circumstances to: (1) certain health care facilities or health care providers when disclosure is necessary to provide appropriate care to the patient or the child of a patient; (2) government health officers where disclosure is mandated by federal or state law; (3) third party reimbursers or their agents to the extent necessary to reimburse providers for their services; (4) insurance institutions, when authorized by the person with authority to consent to health services; (5) any person to whom disclosure is ordered by court; and (6) correctional facilities and employees, under certain circumstances. N.Y. PUB. HEALTH LAW § 2782 (McKinney 2001). Generally, once they have received the information, the above listed individuals and facilities may not redisclose the information. It is important to note that only physicians, other health professionals, health facilities and social service workers are prohibited from disclosing HIV-related information. These laws do not apply to those who obtain such information in non-professional capacities (such as friends, family members, landlords, neighbors, etc.). Further, in New York, there is no civil privacy remedy for disclosure of confidential medical information by persons not bound by confidentiality laws, although there may be federal civil claims against such disclosures by government actors.
- 111 N.Y. PUB. HEALTH LAW § 2781(1) (McKinney 2001). Only in very limited contexts, for example when a person’s HIV status is at issue in a lawsuit (*see* N.Y. C.P.L.R. § 3121(1) (McKinney 2001)), can an HIV test be ordered without the individual’s consent. *See also* N.Y. PUB. HEALTH LAW § 2785-a (McKinney 2001) (requiring public health officers to administer HIV related testing to the subject of an order associated with a criminal or family court proceeding, and requiring disclosure of the test results to the subject and the victim who requested the order).
- 112 N.Y. PUB. HEALTH LAW § 2780(5) (McKinney 2001).
- 113 Pursuant to N.Y. PUB. HEALTH LAW § 2500-f (McKinney 2001), the New York State Department of Health has implemented a screening program to test newborns for HIV without parental consent, and to disclose the results to the mother. 10 N.Y.C.R.R. § 69-1 (2001).
- 114 Locations of anonymous testing sites can be obtained from New York State Department of Health regional offices, listed at <http://www.health.state.ny.us/nysdoh/aids/hivtesti.htm>.
- 115 N.Y. PUB. HEALTH LAW §§ 2780(7), 2782(1) (McKinney 2001).
- 116 Such providers will be fined up to \$5,000, will be guilty of a misdemeanor crime [ANNA NOTE] and will be guilty of professional misconduct (N.Y. PUB. HEALTH LAW § 2783(1)(b) (McKinney 2001)).
- 117 N.Y. PUB. HEALTH LAW § 2782(4)(e) (McKinney 2001).
- 118 N.Y. PUB. HEALTH LAW § 2782(4)(e)(2) (McKinney 2001).
- 119 N.Y. PUB. HEALTH LAW § 2782(4)(e)(2)(B) (McKinney 2001).
- 120 N.Y. PUB. HEALTH LAW § 2780(5) (McKinney 2001) (defining capacity to consent as pertaining to any individual, without regard to age).
- 121 N.Y. PUB. HEALTH LAW § 2782(1)(h) (McKinney 2001).
- 122 N.Y. SOC. SERV. LAW § 373-a (McKinney 2001).
- 123 N.Y. PUB. HEALTH LAW § 2782(1)(p) (McKinney 2001).
- 124 Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 18 (June 29, 2000). [NOTE TO MIKE THAT 122-123 SWITCHED WITH 124-125]
- 125 N.Y. PUB. HEALTH LAW § 2782(5)(a) (McKinney 2001).
- 126 N.Y. PUB. HEALTH LAW §§ 2782(1)(k), 2785 (McKinney 2001).
- 127 N.Y. PUB. HEALTH LAW § 2785 (McKinney 2001).
- 128 N.Y. PUB. HEALTH LAW §§ 2(1)(b), 2130(1) (McKinney 2001); 10 N.Y.C.R.R. § 63.4(a)(1) (2001). Others mandated to report such test findings and diagnoses include medical personnel who are authorized to order diagnostic tests or make medical diagnoses, their agents and any laboratories performing such tests.
- 129 The reporting law is triggered when a patient gets an *initial* test for HIV that turns out positive, when a patient receives an *initial* diagnosis that he or she has AIDS, HIV or an HIV-related illness (including diagnoses of new opportunistic infections). For example, when a patient undergoes a diagnostic test when he or she *begins* medical treatment for HIV/AIDS or when he or she switches providers, the diagnostic test is likely to trigger

- the reporting requirements. N.Y. PUB. HEALTH LAW § 2130(1) (McKinney 2001); 10 N.Y.C.R.R. § 63.4(a)(1) (2001). Laboratories must also report all positive diagnostic tests (i.e., any blood or other lab test that a patient may receive in the course of ongoing care), regardless of the patient's stage of treatment.
- 130 The reporting law is triggered when a patient is initially diagnosed as HIV-positive or when a patient receives an initial diagnosis that he or she has AIDS, or an HIV-related illness (including diagnoses of new opportunistic infections). For example, when a patient undergoes a diagnostic test when he or she begins medical treatment for HIV/AIDS or when he or she switches providers, the diagnostic test is likely to trigger the reporting requirements. N.Y. PUB. HEALTH LAW § 2130(1) (McKinney 2001); 10 N.Y.C.R.R. § 63.4(a)(1) (2001). *Laboratories must also report the results of certain HIV-related tests (i.e., any blood or other lab test that a patient may receive in the course of ongoing care), regardless of the patient's stage of treatment.* See 10 N.Y.C.R.R. § 63.4(a)(4)(i), (a)(4)(ii).
- 131 10 N.Y.C.R.R. § 63.4(b) (2001); N.Y. PUB. HEALTH LAW § 2130(3) (McKinney 2001) [defining "known" contacts as including those known independently to the physician or revealed to the physician by the infected person].
- 132 10 N.Y.C.R.R. § 63.4(b) (2001); N.Y. PUB. HEALTH LAW § 2130(3) (McKinney 2001).
- 133 In fact, New York law calls only for physicians or public health officials to seek the *cooperation* of infected individuals. 10 N.Y.C.R.R. § 63.8(a)(3) (2001).
- 134 N.Y. PUB. HEALTH LAW § 2136(3) (McKinney 2001).
- 135 10 N.Y.C.R.R. § 63.8(i) (2001).
- 136 10 N.Y.C.R.R. § 63.8(a)(3) (2001).
- 137 *Id.*; N.Y. PUB. HEALTH LAW § 2782(4)(b) (McKinney 2001).
- 138 The notification deferment lasts until the issue is revisited within 30-120 days. Hayley Gorenberg, *HIV Case Reporting and Partner Notification Laws*, N.Y.L.J., June 2, 2000, at 6 (citing *NYS-DOH Protocol for Domestic Violence Screening of HIV-Infected Individuals in Relation to HIV Counseling, Testing Referral and Partner Notification*, at 3-5).
- 139 See *supra* note 125.
- 140 N.Y. PUB. HEALTH LAW § 2782(4)(a) (McKinney 2001).
- 141 *Id.*; 10 N.Y.C.R.R. § 63.8(a)(1) (2001).
- 142 N.Y. PUB. HEALTH LAW § 2783(3)(a) (McKinney 2001) immunizes health providers against civil and criminal liability for failure to disclose confidential HIV related information to a contact or to a person authorized to consent to the patient's health care.
- 143 N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 2001).
- 144 N.Y. PUB. HEALTH LAW § 2504(1)-(2) (McKinney 2001).
- 145 A minor sexual assault survivor always should be offered emergency contraception where medically appropriate if she was subject to unprotected intercourse in the preceding 72 hours, according to a protocol issued by the State Departments of Health and Social Services. DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 49 (n.d.). Notwithstanding this protocol, not all hospitals provide emergency contraception as part of the medical services associated with a sexual assault. A patient should ask specifically for this service if so desired and if it is not automatically offered.
- 146 DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 33 (n.d.).
- 147 Survivors should note that not all hospitals are equipped with sexual assault "kits" and should therefore inquire as to the availability thereof before going to the hospital, if possible.
- 148 Because health providers may not claim "doctor-patient privilege" relating to medical information that indicates that a patient under the age of 16 has been the victim of a crime (see p. 34 & note 77), control over the progression of a criminal investigation may be more complicated for teenagers aged 15 and younger. For such minors, when someone in law enforcement makes a request to a provider for health records relating to the minor's sexual assault, the provider may not refuse (although if he or she is uncomfortable with the request, he or she may consult an attorney). Therefore, if law enforcement is already involved (for example, the minor was taken to the hospital by the police), the minor may not entirely be able to halt the progression of a criminal case. A provider is still, however, under duties of confidentiality and may not report a minor's sexual assault to the police without the patient's consent (see pp. 34).
- 149 Sexual assault treatment generally consists of a medical history, a physical examination, an anogenital examination, testing and prophylaxis for HIV and sexually transmitted diseases, emergency contraception, pregnancy testing and counseling, treatment for any other injuries, rape crisis counseling, referrals for additional services and the collection of forensic evidence.
- 150 Minors who can give informed consent may consent to pregnancy testing and counseling, administration of emergency contraception, STI diagnosis and treatment, HIV testing and treatment, and forensic evidence collection. A minor may still consent to other treatment related to the assault that does not fall within one of these exceptions (e.g., treatment for injuries from the assault), see *infra* note 149 and accompanying text.
- 151 N.Y. C.P.L.R. 4510(a)(3) (defining the rape crisis client, without regard to age, as "*any person* who is seeking or receiving the services of a rape crisis counselor for the purpose of securing counseling or assistance concerning any sexual offenses") (emphasis added).
- 152 DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 33 (n.d.) (directing providers to obtain consent from sexual assault survivors, including capable minors, before collecting sexual offense evidence).
- 153 New York law governing sexual assault treatment standards specifically includes "evidence which is associated with the hospital's treatment of

- injuries sustained as a result of a sexual offense” within its definition of “privileged sexual offense evidence.” 10 N.Y.C.R.R. § 405.9(c)(4) (2001).
- 154 N.Y. PUB. HEALTH LAW §§ 17, 2306 (McKinney 2001).
- 155 DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 15, 33 (n.d.) (noting that refusal to consent by any minor be considered and that child protective services guidelines require providers to honor the refusal to consent by a minor who is capable of understanding the nature and consequences of the choice).
- 156 If Susan consents under pressure from her mother, the emergency room providers still should decline to perform the examination if they determine that the consent was the result of force or coercion. Forced consent is not valid consent.
- 157 DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 20 (n.d.).
- 158 N.Y. PUB. HEALTH LAW § 2805-i(2) (McKinney 2001) (requiring patient consent to release privileged sexual offense evidence); DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 48 (n.d.) (requiring written authorization and consent of an informed mature minor to release sexual offense evidence).
- 159 10 N.Y.C.R.R. § 405.9(c) (2001) (giving the sexual assault survivor the authority to decide whether evidence is to be collected and turned over to the police). In situations where the survivor sustained a gun-shot or serious stab wound, a hospital must report such wounds to the police, although other information, such as how the injuries were sustained, should not be disclosed by the provider, *see infra* note 160.
- 160 N.Y. SOC. SERV. LAW § 413(1) (McKinney 2001); *see pp.* 30-32. Such reports must be made to the State Central Register of Child Abuse and Maltreatment, *not* the police.
- 161 N.Y. C.P.L.R. §§ 4504(b), 4508(a)(3) (McKinney 2001).
- 162 N.Y. PENAL LAW § 265.25 (McKinney 2001) (requiring reports of such wounds to be made to the police). In addition, certain burns must be reported to the New York State Office of Fire Prevention and Control (OFPC). N.Y. PENAL LAW § 265.26 (McKinney 2001).
- 163 *See p.* 34.
- 164 Although these reports must include some personally identifiable information, information regarding the circumstances around which the injuries were sustained is not reportable and the police or OFPC will not release patient information to third parties unless a criminal investigation ensues. Telephone Interview with Margaret Smith, Secretary, New York State Office of Fire Prevention and Control (October 18, 2001).
- 165 N.Y. MENTAL HYG. LAW § 33.21(c) (McKinney 2001); 14 N.Y.C.R.R. § 587.7(a)(3)(iii) (2001). Where parents have refused to consent and a physician determines that the minor should receive treatment anyway, the physician must notify the parents of this decision, but *only* if clinically appropriate.
- 166 N.Y. MENTAL HYG. LAW § 33.21(b) (McKinney 2001). “Outpatient mental health services” includes all services—including medication—provided in a New York State licensed outpatient program, N.Y. MENTAL HYG. LAW § 33.21(a)(3) (McKinney 2001), except for surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures, N.Y. MENTAL HYG. LAW § 33.03(b)(4) (McKinney 2001).
- 167 N.Y. MENTAL HYG. LAW § 33.21(d) (McKinney 2001).
- 168 Such documentation must include a written statement signed by the minor indicating that he or she is voluntarily seeking services. N.Y. MENTAL HYG. LAW § 33.21(c) (McKinney 2001).
- 169 N.Y. MENTAL HYG. LAW § 9.13(a) (McKinney 2001). When a minor is on voluntary admission to a hospital on his or her own application, parental consent for medication is not needed. N.Y. MENTAL HYG. LAW § 33.21(a)(1) (McKinney 2001). For other minors residing in a hospital, parental consent generally is necessary for the non-emergency administration of psychotropic medications. N.Y. MENTAL HYG. LAW § 33.21(e)(1) (McKinney 2001). However, a sixteen- or seventeen-year-old who provides informed consent can receive medication without parental consent where medication is in the minor’s best interests if: (1) a parent or guardian is not reasonably available, (2) requiring parental involvement would have a detrimental effect on the minor or (3) the parent or guardian has refused to consent. N.Y. MENTAL HYG. LAW § 33.21(e)(2) (McKinney 2001).
- 170 N.Y. MENTAL HYG. LAW § 9.07(a) (McKinney 2001).
- 171 N.Y. MENTAL HYG. LAW § 9.09 (McKinney 2001).
- 172 N.Y. MENTAL HYG. LAW § 9.13(b) (McKinney 2001) (allowing the involuntary commitment of an individual if he or she is “mentally ill and in need of retention for involuntary care or treatment”); N.Y. MENTAL HYG. LAW § 9.01 (McKinney 2001) (“[I]n need of involuntary care and treatment” means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person’s welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment.”). Under constitutional law, however, the standard for involuntary commitment is actually more stringent. As a matter of substantive due process, a person cannot be committed involuntarily unless the patient presents a real and present danger to himself or others. *See, e.g., O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (“[A] State cannot constitutionally confine without more a [mentally ill] nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”); *Rodriguez v. City of N.Y.*, 72 F.3d 1051, 1061 (2d Cir. 1995) (“[D]ue process does not permit the involuntary hospitalization of a person who is not a danger either to herself or to others.”).
- 173 N.Y. MENTAL HYG. LAW § 9.13 (b) (McKinney 2001).
- 174 *See, e.g., Rodriguez*, 72 F.3d at 1061.
- 175 N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 2001).

- 176 N.Y. MENTAL HYG. LAW § 33.16(c)(2) [McKinney 2001]. A provider also may deny such a request if he or she determines that disclosure of the records would have a detrimental effect on the relationship between the patient and provider, on the relationship between the patient and his or her parents/guardians or on the minor's care and treatment. N.Y. MENTAL HYG. LAW § 33.16(b)(3) [McKinney 2001].
- 177 See, e.g., AMERICAN PSYCHIATRIC ASSOCIATION, ETHICS PRIMER OF THE AMERICAN PSYCHIATRIC ASSOCIATION 16-17 (2001).
- 178 N.Y. Mental Hyg. Law §§ 33.23, 33.25, 45.07 [McKinney 2008].
- 179 Emergency Regulations to implement Jonathan's Law, effective Mar. 27, 2008, available at http://www.omr.state.ny.us/regs/hp_regs_jlaw.jsp [adding section (h) to 14 N.Y.C.R.R. §624.6].
- 180 See N.Y. Comp. R. & Regs. [N.Y.C.R.R.] tit. 14, § 624.5 (2008). N.Y. Mental Hygiene Law § 13.21 [McKinney 2002]; see also 14 N.Y.C.R.R. §§ 624.3(d); 633.3(d); N.Y. Mental Hygiene Law §16.13(b) (referring to OMRDD facilities) [McKinney 2002]; see also 14 N.Y.C.R.R. §§ 624.3(d), (g); 633.3(d). N.Y. Mental Hygiene Law § 31.11 (referring to OMH facilities) [McKinney 2002]; 14 N.Y.C.R.R. § 524.2(d)
- 181 N.Y. MENTAL HYG. LAW § 22.11(b) [McKinney 2001] (“[T]he important role of the parents or guardians shall be recognized...[and s]teps shall be taken to involve the parents or guardians in the course of [mental health] treatment.”).
- 182 Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 16 (June 29, 2000).
- 183 When treating a minor without parental consent, a health care provider must document the reasons that parental consent was not sought or obtained, and a minor must always be informed that he or she is entitled to legal counsel upon request. N.Y. MENTAL HYG. LAW § 22.11(c)(1), (d)(2) [McKinney 2001].
- 184 N.Y. MENTAL HYG. LAW § 22.11(c)(1) [McKinney 2001]; 14 N.Y.C.R.R. 820.4(c) [2001].
- 185 N.Y. MENTAL HYG. LAW § 22.11(a)
- 186 14 N.Y.C.R.R. 820.4(c) [2001].
- 187 42 U.S.C.S. § 290dd-2(a) [2001] (“Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with...any program or activity” conducted at a federally-assisted substance abuse and prevention facility “shall...be confidential.”) Disclosure is only allowed pursuant to the patient's consent, to a court order, in a medical emergency, or as necessary to comply with state child abuse reporting laws. 42 U.S.C. § 290dd-2(b), 2(e) [2001].
- 188 Commissioner of Social Serv. v. David R.S., 436 N.E.2d 451, 453-455 (N.Y. 1981) [noting that “it is a matter of high priority and prime concern that the effectiveness of drug abuse treatment programs offered by facilities receiving Federal support not be jeopardized by court-ordered disclosure of information gained about those who submit themselves to such facilities”].
- 189 42 U.S.C.A. § 290dd-2(c).
- 190 42 C.F.R. § 2.14(b) [2001] (allowing a minor patient who has the legal capacity to consent to treatment to direct disclosure of information); Memorandum from Henry M. Greenberg, General Counsel, New York State Department of Health, to Dennis P. Murphy, Acting Director, Division of Family and Local Health 16 (June 29, 2000) [stating that parental consent is not needed for non-medical substance abuse services in New York].
- 191 N.Y. PUB. HEALTH LAW § 2504(4) [McKinney 2001].
- 192 Sullivan v. Montgomery, 279 N.Y.S. 575, 577 (City Ct. 1935).
- 193 N.Y. PUB. HEALTH LAW § 18(2)(c) [McKinney 2001].
- 194 *Id.*
- 195 The disclosable medical history includes information setting forth conditions or diseases believed to be hereditary, drugs and/or medication taken during pregnancy by the child's birth mother, and any other medical information, including psychological information that may influence the child's current or future health. N.Y. SOC. SERV. LAW § 373-a [McKinney 2001].
- 196 N.Y. PUB. HEALTH LAW § 2782(1)(h) [McKinney 2001] (“No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to the following...an authorized agency in connection with foster care or adoption of a child.”).
- 197 N.Y. SOC. SERV. LAW § 373-a [McKinney 2001]
- 198 18 N.Y.C.R.R. §§ 441.22(a), 507.1(a) [2001].
- 199 18 N.Y.C.R.R. § 507.1(c)(9) [2001].
- 200 For specific information on the income and immigrant status eligibility requirements, as well as the details concerning how a young person enrolls in one of these programs, please consult a teen advocacy organization, such as The Door, listed in the back of this booklet, or call one of the phone numbers included in this section.
- 201 Children's Aid Society, *Medicaid and CHP Enrollment for Adolescents*, February 2000.
- 202 *Id.*
- 203 *Id.*
- 204 *Id.*
- 205 N.Y. SOC. SERV. LAW § 366-g [McKinney 2001]; 18 N.Y.C.R.R. § 360-3.3(c)(6) [2001].
- 206 42 U.S.C. § 1396(e)(4) [2001]; 42 C.F.R. § 435.117(a) [2001]. See also N.Y. Soc. SERV. LAW § 366-g [McKinney 2001] (“A child under the age of one year whose mother is receiving medical assistance, or services under the prenatal

- care assistance program...shall be deemed to be enrolled in the medical assistance program regardless of the issuance of a medical assistance identification card or client identification number to such child or other proof of the child's eligibility.”).
- 207 N.Y. PUB. HEALTH LAW §§ 2520-2529 (McKinney 2001).
- 208 N.Y. PUB. HEALTH LAW § 2521(3) (McKinney 2001).
- 209 Children’s Aid Society, *Medicaid and CHP Enrollment for Adolescents*, February 2000.
- 210 N.Y. PUB. HEALTH LAW §§ 2521(3), 2529(2)(a) (McKinney 2001).
- 211 Children’s Aid Society, *Medicaid and CHP Enrollment for Adolescents*, February 2000.
- 212 DEPARTMENT OF HEALTH, APPLICATION No. 4133, GROWING UP HEALTHY: HEALTH INSURANCE AND NUTRITION FOR CHILDREN, TEENS AND PREGNANT WOMEN, CHILD HEALTH PLUS, MEDICAID AND WIC (n.d.).
- 213 The prenatal care services available under PCAP include prenatal risk assessment, prenatal care visits and the transportation for such visits, laboratory services, health education, referrals for pediatric care and nutrition services, mental health services, labor and delivery services, post-partum care and family planning services, inpatient care related to delivery and recovery, dental services, emergency room services, home care, and medication. N.Y. PUB. HEALTH LAW § 2522(1) (McKinney 2001).
- 214 If the income of a minor and/or her spouse is greater than the federal poverty level, abortions will not be covered for that minor under PCAP. However, because most minors do not earn an income that is greater than the federal poverty level, abortions will be covered almost all of the time under PCAP.
- 215 N.Y. PUB. HEALTH LAW § 2521(3) (McKinney 2001).
- 216 Letter from Jo-Ann A. Constantino, Deputy Commissioner Division of Medical Assistance, New York State Dep’t of Social Services, to “Provider” (Jan. 22, 1991) (discussing payment for PCAP services for women whose pregnancies end other than in live births) (on file with NYCLU).
- 217 N.Y. SOC. SERV. LAW § 366-g (McKinney 2001); 18 N.Y.C.R.R. § 360-3.3(c)(6) (2001).
- 218 Letter from Gregor Macmillan, Director, Division of Provider Relations, Office of Medicaid Management, New York State Department of Health, to Family Planning Provider (August 27, 1998) (on file with NYCLU).
- 219 *Id.*
- 220 N.Y. PUB. HEALTH LAW §§ 2510-2511 (McKinney 2001).
- 221 N.Y. PUB. HEALTH LAW § 2510(9) (CHP eligibility), § 2511 (McKinney 2001) (defining income eligibility levels for CHP as up to almost twice the federal income poverty level, which sets the standard for Medicaid eligibility, pursuant to N.Y. SOC. SERV. LAW Article 5, Title 11.).
- 222 DEPARTMENT OF HEALTH, APPLICATION No. 4133, GROWING UP HEALTHY: HEALTH INSURANCE AND NUTRITION FOR CHILDREN, TEENS AND PREGNANT WOMEN, CHILD HEALTH PLUS, MEDICAID AND WIC (n.d.).
- 223 Children’s Aid Society, *Medicaid and CHP Enrollment for Adolescents*, February 2000.

