

Confidentiality and Consent:

Why Promising Parental Nondisclosure to Minors in the Military Health System Can Be a Risky Proposition

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In general, Department of Defense (DoD) rules governing the uses and disclosures of protected health information preempt state law, unless DoD policy specifically states otherwise. One such notable exception involves the “disclosure of protected health information about a minor to a parent, guardian, or person acting in loco parentis of such minor,” in which case “the state law of the state where the treatment is provided shall be applied.”¹ So long as the parent, guardian, or person acting in loco parentis has the undisputed authority to make healthcare decisions on behalf of the unemancipated minor patient, the inevitable variations in state disclosure laws are typically not problematic for DoD healthcare personnel. When a parent or guardian has the typical power to provide informed consent for a minor’s healthcare services, that adult will nearly always be granted de facto status as the child’s personal representative for purposes of receiving relevant protected health information.²

What about those cases in which the minor has the right to provide or withhold informed consent to a particular medical procedure, with or without the input of an adult? What, if anything, can the healthcare provider disclose to the minor’s adult caretakers? In these situations, military treatment facilities (MTFs), along with the judge advocates who advise them, find themselves wading into the thickets of state law, based on where the relevant medical service was provided. In applying the respective state law on parental notification in cases of independent minor consent, the MTF may disclose protected health information where permitted or required, must withhold it where prohibited, and will enable licensed healthcare professionals to exercise discretion where the law is silent.³

Instances in which minors seek medical care without their parents’ involvement, and perhaps without their knowledge, tend to be among the most emotionally charged to begin with. Unfortunately, this is also an area where guidance can be less than clear and, hence, where misconceptions abound. A false promise of confidentiality, made innocently but incorrectly by healthcare personnel, runs the risk of exacerbating an already fraught situation, not to mention shattering the minor’s expectation of

nondisclosure. As such, it is vital that MTFs not promise minors confidentiality of treatment vis-à-vis their parents, even when minors can lawfully obtain a healthcare service without their parents’ permission, unless they are justifiably confident that the law mandates, or at the very least permits, such confidentiality in a given case. Even then, the MTF cannot definitively prevent parents from accessing the minor’s medical record or receiving a statement of insurance benefits. Similarly, those of us who advise MTFs must recognize that the ability of a minor to consent to treatment in specified circumstances does not always guarantee that the treatment will be kept confidential from the minor’s parents or guardians. Consent and confidentiality fall under interrelated, but not necessarily identical, medico-legal rubrics and must each be assessed individually.⁴

Informed Consent by Minors

In perhaps the most famous jurisprudential statement on informed consent, Justice Benjamin Cardozo wrote that “every human being of adult years and sound mind has a right to determine what shall be done with his own body.”⁵ Of course, Cardozo’s sweeping pronouncement on bodily autonomy excluded two distinct groups from its scope: minors and others deemed lacking in the requisite decision-making capacity to authorize or refuse medical treatment.

In the United States, the military health system (MHS) defers to state laws governing consent for medical treatment of minors, unless those laws conflict with federal guidelines.⁶ As a general rule, healthcare providers must obtain parental consent before proceeding with treatment of a minor. This longstanding axiom “rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions,” as well as the assumption “that natural bonds of affection lead parents to act in the best interests of their children.”⁷ Exceptions to the general requirement of parental consent fall under two broad categories: those having to do with the minor’s legal status and those concerning the type of healthcare service involved.⁸

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¹ U.S. DEP’T OF DEF., DIR. 6025.18-R, DOD HEALTH INFORMATION PRIVACY REGULATION para. C2.4 (24 Jan. 2003) [hereinafter DODD 6025.18-R].

² *Id.* para. C8.7.3.1.

³ *Id.* para. C8.7.3.2.

⁴ Sara Rosenbaum et al., *Health Information Law in the Context of Minors*, 123 PEDIATRICS S116, S117–118 (2009).

⁵ *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

⁶ *See, e.g.*, U.S. DEP’T OF AIR FORCE, INSTR. 44-102, MEDICAL CARE MANAGEMENT para. 2.6 (1 May 2006) [hereinafter AFI 44-102].

⁷ *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

⁸ David M. Vukadinovich, *Minors’ Rights to Consent to Treatment: Navigating the Complexity of State Laws*, 37 J. HEALTH L. 667, 677 (2004).

Exceptions Based on the Minor's Status

Exceptions in state law based on a minor's status recognize that certain actions or decisions undertaken prior to the statutory age of majority effectively emancipate the minor for some or all purposes and thus remove the presumption that the minor is incapable of independent informed consent to medical treatment. Exceptions of this type rest on state legislative determinations that certain experiences "constitute an act of physical, psychological or economic separation from one's parents," which in turn "encroaches upon the parents' ability to determine the appropriate healthcare for such children."⁹ In addition to a court order, acts typically imbued with emancipating repercussions include marriage, enlistment in the Armed Forces, and, in some cases, a specified time period living apart from and independently of one's parents. Certain state laws eschew the time period calculation in favor of a general determination that the minor is either living self-sufficiently or is homeless.¹⁰ Unlike the relatively clear-cut facts of marriage, military service, or a court order, the self-sufficiency exception requires a subjective determination by the individual medical provider and is therefore not binding upon other providers.¹¹

In addition, some states regard pregnancy¹² or childbirth¹³ as conferring an emancipated status, whereas others perceive it as a specific medical condition that invests minors with control only over treatment related to that condition.¹⁴ The latter view can potentially lead to the uneasy situation in which a minor mother can exercise control over her child's medical treatment, but not over her own, unless such treatment is directly related to her pregnancy or delivery.¹⁵

Some jurisdictions have also recognized the so-called "mature minor" rule, which states that an unemancipated minor's consent may be required, in addition to or instead of the minor's parents, if "the physician's good faith assessment of the minor's maturity level" indicates that "the minor has the capacity to appreciate the nature, risks, and consequences of the medical procedure to be performed, or the treatment to be administered or withheld."¹⁶ Whereas

emancipation typically is concerned with outward signs of independence or self-support, the concept of maturation pertains to developmental cognition.¹⁷ The mature minor rule is largely a judicial, rather than a statutory, doctrine "that extends the common law principle of self-determination to minors";¹⁸ however, some states have enacted mature minor legislation in response to such court decisions.¹⁹ The general applicability of the mature minor doctrine is questionable given that some jurisdictions have outright rejected or simply ignored it.²⁰ Even those that have embraced it caution that the mature minor exception "is by no means a general license to treat minors without parental consent."²¹

Exceptions Based on the Minor's Medical Condition

Perhaps the most prevalent exception based on the type of service rendered is emergency medical care,²² "when failure to treat would result in potential loss of life, limb, or sight."²³ The basis of the emergency exception as it pertains to minors is not that parental consent is unnecessary, but rather that it is presumed.²⁴ Moreover, emergency treatment is less a specific exception to parental consent than an exception to the doctrine of informed consent in general. The emergency care of minors adds an additional wrinkle because attempts must be made to contact and obtain consent from the parents prior to treatment if practicable; after treatment, the parents should also be contacted and back-briefed as soon as possible.²⁵ When unable to make contact with the parents prior to rendering emergency treatment, the healthcare provider should seek a second medical opinion, unless doing so would cause a potentially hazardous delay to the minor patient.²⁶

child, as well as upon the conduct and demeanor of the child at the time of the procedure or treatment." *Id.*

¹⁷ Batterman, *supra* note 9, at 641.

¹⁸ John Alan Cohan, *Judicial Enforcement of Lifesaving Treatment for Unwilling Patients*, 39 CREIGHTON L. REV. 849, 850 (2006).

¹⁹ See, e.g., W. VA. CODE § 16-30C-6(d) (1998) (enacted in response to *Belcher*, 422 S.E.2d 827).

²⁰ *O.G. v. Baum*, 790 S.W.2d 839 (Tex. Ct. App. 1990); *In re Thomas B.*, 574 N.Y.S.2d 659 (N.Y. Misc. 1991); *Novak v. Cobb County Kennestone Hosp. Auth.*, 74 F.3d 1173 (11th Cir. 1996).

²¹ *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987).

²² Some experts consider medical emergencies a separate category "of statutory exceptions to the requirement of parental consent." Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 164 (2000).

²³ U.S. DEP'T OF AIR FORCE, INSTR. 41-115, AUTHORIZED HEALTH CARE AND HEALTH CARE BENEFITS IN THE MILITARY HEALTH SYSTEM (MHS) para. 1.11.1 (28 Dec. 2001) [hereinafter AFI 41-115].

²⁴ Vukadinovich, *supra* note 8, at 677.

²⁵ Albert K. Tsai et al., *Evaluation and Treatment of Minors: Reference on Consent*, 22 ANN. EMERGENCY MED. 1211, 1214 (1993).

²⁶ AFI 41-115, *supra* note 23, para. 1.11.1.

⁹ Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 TOURO L. REV. 637, 640 (1994).

¹⁰ See, e.g., CAL. FAM. CODE § 6922(a) (2004); COLO. REV. STAT. § 13-22-103(1) (2004).

¹¹ Vukadinovich, *supra* note 8, at 680.

¹² PA. CONS. STAT. ANN. tit. 35, § 10101 (2004).

¹³ NEV. REV. STAT. ANN. § 129.030(1)(c) (2003).

¹⁴ CAL. FAM. CODE § 6925(a); VA. CODE ANN. § 54.1-2969(G) (2004).

¹⁵ Vukadinovich, *supra* note 8, at 688.

¹⁶ *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 838 (W.Va. 1992). This factual determination is based "upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the

Various state legislatures have also determined that certain medical conditions pose a grave enough threat to the minor, and perhaps to others, that in such cases the public interest in unfettered access to treatment trumps parental rights. One such exception, rooted in public health concerns, involves sexually transmitted diseases (STDs) and other infectious diseases.²⁷ The American Medical Association (AMA) has opined that “allowing minors to consent for the means of prevention, diagnosis and treatment of STDs, including AIDS” can work “to decrease the spread of STDs in minors.”²⁸ The AMA further encourages its constituent associations “to support enactment of statutes that permit physicians and their co-workers to treat and search for venereal disease in minors legally without the necessity of obtaining parental consent.”²⁹

Other condition-specific exceptions include treatment or counseling for drug or alcohol abuse,³⁰ rape or sexual assault,³¹ and mental health services.³² While the authority to consent for medical services related to sexual assault typically adheres to minors “regardless of age,”³³ the mental health exception applies “a minimum age requirement,” often twelve or older.³⁴ As discussed above, some state laws treat pregnancy or childbirth as a matter of emancipation, while others view pregnancy-related services as a specific medical condition for which minors can consent to treatment or prevention.³⁵ With respect to both contraceptive services and prenatal care, states tend to either explicitly authorize minors to consent or have no statute specifically addressing the issue.³⁶ According to the AMA,

the teenage girl whose sexual behavior exposes her to possible conception should have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs; and the physician so consulted should be free to prescribe or withhold contraceptive advice in

accordance with their best medical judgment.³⁷

Regardless of the nature of the exception to parental consent (aside from emergencies), it is important to note that a minor’s right to exercise informed consent does not guarantee that the minor will be capable of giving informed consent. The onus remains on the provider to make a good faith determination as to whether the minor is sufficiently mature to have the capacity to give informed consent.³⁸ To do otherwise would obviate the very basis of informed consent, because the concept presumes that the patient’s decision is underpinned by an understanding of the nature of the proposed treatment, the relevant potential outcomes, and the alternatives, to include no treatment at all.³⁹

Confidentiality for Minors

As with the issue of informed consent for the medical care of minors, the MHS also defers to state law on the matter of disclosing or withholding minors’ protected health information from adults.⁴⁰ The MHS’s Notice of Privacy Practices asserts that where “state laws concerning minors permit or require disclosure of protected health information,” MTFs “will act consistent with the law of the state where the treatment is provided and will make disclosures following such laws.”⁴¹

In the overwhelming majority of cases, a parent is “the personal representative of the minor child and can exercise the minor’s rights with respect to protected health information, because the parent usually has the authority to make healthcare decisions about his or her minor child.”⁴² However, in those circumstances where the minor, due to either an emancipated status or a specific condition, has the ability to independently consent to or refuse treatment, the possibility remains that the relevant state statute or common law may treat the right of consent and the right to control health information as two distinct concepts.⁴³ Thus, “the fact that a minor can consent to treatment without parental approval is not automatically dispositive of the separate

²⁷ See Vukadinovich, *supra* note 8, at 685–86.

²⁸ AM. MED. ASS’N, HEALTH AND ETHICS POLICY H-60.958, RIGHTS OF MINORS TO CONSENT FOR STD/HIV PREVENTION, DIAGNOSIS AND TREATMENT (1994).

²⁹ AM. MED. ASS’N, HEALTH AND ETHICS POLICY H-440.996(4), GONORRHEA CONTROL (1972).

³⁰ See Vukadinovich, *supra* note 8, at 684–85.

³¹ *Id.* at 686–87.

³² *Id.* at 682–83.

³³ *Id.* at 686.

³⁴ *Id.* at 682.

³⁵ *Id.* at 688–90.

³⁶ Heather Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, GUTTMACHER REP. PUB. POL’Y 4, 6 (Aug. 2000).

³⁷ AM. MED. ASS’N, HEALTH AND ETHICS POLICY H-75.999, TEENAGE PREGNANCY (1971).

³⁸ Vukadinovich, *supra* note 8, at 677.

³⁹ See Timothy J. Paterick et al., *Medical Informed Consent: General Considerations for Physicians*, 83 MAYO CLINIC PROC. 313 (2008).

⁴⁰ DODD 6025.18R, *supra* note 1, para. C2.4.2.1.

⁴¹ MILITARY HEALTH SYSTEM, NOTICE OF PRIVACY PRACTICES (14 Apr. 2003).

⁴² U.S. DEP’T OF HEALTH & HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS, PERSONAL REPRESENTATIVES (3 Apr. 2003) [hereinafter PERSONAL REPRESENTATIVES].

⁴³ Rosenbaum, *supra* note 4, at S118.

question of whether a minor can control the privacy of such information with respect to parents or third parties.”⁴⁴

At first glance, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule appears to give wide latitude in this area, enabling minors who control their healthcare decisions to also control their protected health information. Indeed, the three specific exceptions to parental access to health information “generally track the ability of certain minors to obtain specified healthcare without parental consent.”⁴⁵ These exceptions include instances where (1) the minor consents to a particular healthcare service and no parental consent is required,⁴⁶ (2) a court or provision of law empowers someone other than the parent to consent to a healthcare service for a minor and that person or entity does so,⁴⁷ and (3) a parent agrees to confidentiality between the minor and a medical provider with respect to the relevant service.⁴⁸

Commentators have correctly noted that the confidentiality right afforded to minors by the HIPAA Privacy Rule is, on its face, quite sweeping, because it focuses on whether a minor “could have” obtained a given healthcare service in the absence of parental consent.⁴⁹ Indeed, the first exception to parental control over protected health information specifically notes that its focus is on whether the minor who gave informed consent to a particular service had the power to do so, “regardless of whether the informed consent of another person has also been obtained.”⁵⁰ As such, “a minor patient may have a confidentiality right in health information resulting from services to which the minor is authorized under state law to consent even if, in practice, the minor’s parent or guardian actually gives consent.”⁵¹

However, what this analysis overlooks is the language that immediately follows the description of circumstances in which parents lose their status as personal representatives regarding a minor’s protected health information. “Notwithstanding the provisions of” the Privacy Rule barring parental access to certain information,⁵² an MTF may disclose a minor’s protected health information to a parent “to the extent permitted or required by an applicable provision of State or other law, including applicable case

law”;⁵³ may not disclose such information “to the extent prohibited by an applicable provision of State or other law, including applicable case law”;⁵⁴ and may provide or deny access “where there is no applicable access provision under State or other law, including case law . . . if such action is consistent with State or other applicable law, if such decision must be made by a licensed healthcare professional in the exercise of professional judgment.”⁵⁵ The Privacy Rule makes clear that the use of the word “may” in this context is not meant to suggest that MTFs can choose whether to comply with state law, but rather reflects the variances in such laws from state to state. “In cases involving disclosure of protected health information about a minor to a parent, guardian, or person acting in loco parentis of such minor,” the Rule flatly asserts that “the State law of the State where the treatment is provided shall be applied.”⁵⁶ This deference to state laws “that require, permit, or prohibit” the disclosure of a minor’s protected health information to parents holds true even in those “exceptional circumstances,” previously discussed, “where the parent is not the ‘personal representative’ of the minor.”⁵⁷

If the Privacy Rule allows state law to control in this regard, it can end up giving “parents access to minors’ health information that would seem to be prohibited under the Rule” itself.⁵⁸ So, does the Privacy Rule’s continuing deference to state statutory or common law, “notwithstanding” its three exceptions to parents’ de facto status as personal representatives, effectively negate the exceptions altogether? It *can*, but not necessarily will, depending on the relevant state law and the particular healthcare service rendered. For example, Nevada law states that “the consent of the parent, parents or legal guardian of the minor is not necessary to authorize” care “for the treatment of abuse of drugs or related illnesses.”⁵⁹ However, “any physician who treats a minor pursuant to” such provision “shall make every reasonable effort to report the fact of treatment to the parent, parents or legal guardian within a reasonable time after treatment.”⁶⁰ Colorado similarly authorizes any physician licensed to practice in the state to “examine, prescribe for, and treat” a minor patient “for addiction to or use of drugs” with only the minor’s consent. Unlike Nevada, though, Colorado adds that such treatment can be accomplished “without the consent of *or notification to* the parent, parents, or legal guardian of such

⁴⁴ *Id.* at S120.

⁴⁵ PERSONAL REPRESENTATIVES, *supra* note 42.

⁴⁶ DODD 6025.18R, *supra* note 1, para. C8.7.3.1.1.

⁴⁷ *Id.* para. C8.7.3.1.2.

⁴⁸ *Id.* para. C8.7.3.1.3.

⁴⁹ Vukadinovich, *supra* note 8, at 669.

⁵⁰ DODD 6025.18R, *supra* note 1, para. C8.7.3.1.1.

⁵¹ Vukadinovich, *supra* note 8, at 669.

⁵² DODD 6025.18R, *supra* note 1, para. C8.7.3.2.

⁵³ *Id.* para. C8.7.3.2.1.

⁵⁴ *Id.* para. C8.7.3.2.2.

⁵⁵ *Id.* para. C8.7.3.2.3.

⁵⁶ *Id.* para. C2.4.2.1.

⁵⁷ PERSONAL REPRESENTATIVES, *supra* note 42.

⁵⁸ Rosenbaum, *supra* note 4, at S119.

⁵⁹ NEV. REV. STAT. ANN. § 129.050 (2003).

⁶⁰ *Id.*

minor patient.”⁶¹ Thus, “healthcare providers in Colorado cannot be compelled to release to a parent a minor’s medical records” pertaining to drug addiction,⁶² whereas Nevada physicians may have an affirmative duty to do so.

The HIPAA Privacy Rule and Its Evolution

Advocates of stronger privacy rights for adolescents and teenagers, who object to HIPAA’s deference to state laws that provide “less stringent” confidentiality protection for minors,⁶³ point to changes in the Privacy Rule effectuated in 2002 as the source of their current predicament.⁶⁴ In late December 2000, in response to HIPAA’s 1996 mandate to develop regulations governing the security and privacy of electronic health records, the Department of Health and Human Services (HHS) issued its final Privacy Rule.⁶⁵ The final rule recited the three previously mentioned exceptions precluding parents from acting as the personal representatives of their minor children, but it did not include the language immediately following those exceptions deferring to state law.⁶⁶ However, this earlier version of the final rule did explicitly state that “nothing in this subchapter may be construed to preempt any State law to the extent that it authorizes or prohibits disclosure of protected health information about a minor to a parent, guardian, or person acting *in loco parentis* of such minor.”⁶⁷ This disclaimer was included under a discussion of state laws that were “more stringent” than the federal regulation being promulgated,⁶⁸ which has led some commentators to determine—contrary to the language of the disclaimer itself—that the 2000 Privacy Rule deferred “only to more-stringent state law.”⁶⁹

This interpretation of the rule was never put to a practical test. In April 2001, nearly two years before the Privacy Rule’s compliance date, the new Administration announced its intention to “consider any necessary modifications” to the final rule from the previous year. One of HHS’s stated goals in modifying the rule was to “make it clear” that “parents will have access to information about the

health and well-being of their children.”⁷⁰ The modified final Privacy Rule,⁷¹ promulgated in August 2002 after a new round of notice and comments, added the previously discussed “notwithstanding” language immediately following its discussion of circumstances in which parents are precluded from controlling minors’ protected health information.⁷² In so doing, the modified rule moved the language on disclosing protected health information about a minor to a parent from the discussion of “more stringent” state laws in the 2000 rule, to the section on “standards regarding parents and minors” in the 2002 iteration.⁷³ Moreover, whereas the 2000 rule had explicitly deferred to state law “to the extent that it authorizes or prohibits disclosure of protected health information” about minors to parents,⁷⁴ the 2002 rule extended the terms of deference where state law either “permitted,” “required,” or “prohibited” disclosure.⁷⁵ According to HHS’s analysis, this change was intended to correct an “unintended consequence” of the earlier rule, which “may have prohibited parental access in certain situations in which State or other law may have permitted such access.”⁷⁶ In addition, the modified Privacy Rule specifically granted autonomy to “a licensed healthcare professional, in the exercise of professional judgment”⁷⁷ in cases where “state and other laws are silent or unclear.”⁷⁸ According to HHS, this change addressed a second “unintended consequence” of the prior Administration’s rule, which “fail[ed] to assure that State or other law governs when the law grants a provider discretion in certain circumstances to disclose protected health information to a parent.”⁷⁹

It is probably an overstatement to argue, as do some youth advocates, that the 2002 modified regulation “severs the existing link between minors’ right to consent to healthcare and their ability to keep their medical records private.”⁸⁰ A more accurate description of the Privacy Rule and its evolution recognizes that the rule’s “provisions represent a compromise between competing viewpoints about the importance of parental access to minors’ health

⁶¹ COLO. REV. STAT. § 13-22-102 (1999) (emphasis added).

⁶² Cynthia Dailard, *New Medical Records Privacy Rule: The Interface with Teen Access to Confidential Care*, GUTTMACHER REP. PUBLIC POL’Y 6, 7 (Mar. 2003).

⁶³ Rosenbaum, *supra* note 4, at S119.

⁶⁴ *See, e.g.*, Dailard, *supra* note 62, at 7.

⁶⁵ Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (28 Dec. 2000).

⁶⁶ *Id.* at 82,806.

⁶⁷ *Id.* at 82,800.

⁶⁸ *Id.*

⁶⁹ Rosenbaum, *supra* note 4, at S119.

⁷⁰ STATEMENT BY HHS SECRETARY TOMMY G. THOMPSON REGARDING THE PATIENT PRIVACY RULE (12 Apr. 2001).

⁷¹ Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,182 (14 Aug. 2002).

⁷² *Id.* at 53,267.

⁷³ *Id.* at 53,201.

⁷⁴ Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (28 Dec. 2000).

⁷⁵ Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,267.

⁷⁶ *Id.* at 53,200.

⁷⁷ *Id.* at 52,367.

⁷⁸ *Id.* at 53,201.

⁷⁹ *Id.* at 53,200.

⁸⁰ Dailard, *supra* note 62, at 7.

information and the availability of confidential adolescent healthcare services.”⁸¹ Although it is relatively clear from the regulatory history that the Clinton Administration placed more emphasis on adolescent confidentiality, while the succeeding Bush Administration leaned more towards parental notification, the 2002 “final version reflects compromise and a balance among competing views.”⁸² During the comment period between HHS’s proposed modifications to the Privacy Rule in March 2002 and the issuance of the final modifications that August, professional healthcare organizations openly favored protecting “minors’ privacy when they are legally authorized to consent to their own healthcare.”⁸³ While the final modifications may afford “minors somewhat less control over parents’ access to their health information” than the 2000 rule and may give “providers and health plans greater discretion regarding parental access to minors’ health information,” the rule’s general deference to state law and professional standards remained largely unchanged.⁸⁴ In lieu of “sweeping changes in adolescents’ ability to access services on a confidential basis,” the rule “in the end left the status quo essentially intact.”⁸⁵

One of HHS’s stated “goals with respect to the parents and minors provisions in the Privacy Rule” was not “to interfere with the professional requirements of State medical boards or other ethical codes of healthcare providers with respect to confidentiality of health information or with the healthcare practices of such providers with respect to adolescent healthcare.”⁸⁶ According to some commentators, “this statement would suggest that healthcare providers can continue to uphold the recommendations of professional societies that champion confidential healthcare for minors.”⁸⁷ Professional medical associations generally advocate encouraging minors to involve their parents in healthcare decision-making, but also support protecting a competent minor’s confidentiality where the physician is so requested and the law so allows. For example, “where the law does not require otherwise,” the AMA believes that “physicians should permit a competent minor to consent to

medical care and should not notify parents without the patient’s consent.”⁸⁸

Special Cases

In the context of parental notification, there are two special cases in which the MHS does not automatically defer to state law. The first involves services specifically marketed to or designed for potential alcohol and drug abusers, which must “be in compliance with the confidentiality requirements for drug and alcohol treatment.”⁸⁹ The second involves suspected abuse, neglect, or endangerment.⁹⁰

The regulation governing the confidentiality of substance abuse treatment records,⁹¹ promulgated under the Public Health Service Act,⁹² encompasses “some of the most protective confidentiality rules in federal law.”⁹³ The DoD’s implementation of the HIPAA Privacy Rule notes that “covered entities shall comply with the special rules protecting the confidentiality of alcohol and drug abuse patient records in federally assisted alcohol and drug abuse programs.” When applicable, MTFs must comply with both the Privacy Rule and the confidentiality rule for substance abuse treatment records. If the rules conflict, the stricter of the two controls: “To the extent any use or disclosure is authorized by [the Privacy Rule] but prohibited” by the drug and alcohol abuse treatment confidentiality rule, DoD regulation directs that “the prohibition shall control.”⁹⁴ Similarly, if “any use or disclosure is authorized by [the confidentiality rule] but prohibited by [the Privacy Rule], the prohibition shall control. Covered alcohol and drug abuse patient records may only be used or disclosed if the requirements of both [the Privacy Rule] and [the confidentiality rule] are satisfied.”⁹⁵

In order for protected health information covered by the Privacy Rule to also qualify as an alcohol and drug abuse patient record covered by the confidentiality rule, two conditions must be met. “First, the provider, program, or facility must be ‘federally assisted,’” which is a given in the

⁸¹ Abigail English & Carol A. Ford, *The HIPAA Privacy Rule and Adolescents: Legal Questions and Clinical Challenges*, 36(2) PERSPECT. SEXUAL & REPROD. HEALTH 80 (Mar.–Apr. 2004).

⁸² *Id.* at 81.

⁸³ Carol A. Ford & Abigail English, *Limiting Confidentiality of Adolescent Health Services: What Are the Risks?*, 288(6) J. AM. MED. ASS’N 752, 753 (14 Aug. 2002).

⁸⁴ English & Ford, *supra* note 81, at 81.

⁸⁵ *Id.* at 85.

⁸⁶ Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,267 (14 Aug. 2002).

⁸⁷ Pedro Weisleder, *The Right of Minors to Confidentiality and Informed Consent*, 19(2) J. CHILD NEUROLOGY 145, 147 (Feb. 2004).

⁸⁸ AM. MED. ASS’N, HEALTH AND ETHICS POLICY E-5.055, CONFIDENTIAL CARE FOR MINORS (1994) [hereinafter CONFIDENTIAL CARE FOR MINORS].

⁸⁹ U.S. DEP’T OF DEF., INSTR. 1010.6, REHABILITATION AND REFERRAL SERVICES FOR ALCOHOL AND DRUG ABUSERS para. 5.2.3 (13 Mar. 1985) [hereinafter DoDI 1010.6].

⁹⁰ See DoDI 6025.18R, *supra* note 1, para. C8.7.5.

⁹¹ 42 C.F.R. Pt. 2 (2002).

⁹² 42 U.S.C. § 290dd-2 (1998).

⁹³ Rebecca Gudeman, *Federal Privacy Protection for Substance Abuse Treatment Records: Protecting Adolescents*, 24(3) YOUTH L. NEWS 28 (July.–Sept. 2003).

⁹⁴ DoDD 6025.18R, *supra* note 1, para. C8.9.

⁹⁵ *Id.*

MHS. Second, the provider, program, facility, or a unit thereof must “hold itself out as providing alcohol or drug abuse diagnosis, treatment, or referral for treatment,” or else have identified an individual employee who serves primarily “as a provider of alcohol or drug abuse diagnosis, treatment, or referral.”⁹⁶ This definition clearly covers specially designed programs such as the Army’s Substance Abuse Program (ASAP)⁹⁷ and the Air Force’s Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program.⁹⁸ However, it would not apply to a typical MTF emergency department, nor to a family medicine or pediatric clinic, unless that unit has designated a specific provider as a substance abuse specialist or otherwise presents itself as a resource for such services.⁹⁹

Where the substance abuse treatment confidentiality rule does apply, the protections against parental notification are much stronger than those normally afforded under the Privacy Rule. For example, where state law does not require parental consent for a minor to access alcohol or drug abuse treatment, written consent for disclosure “may be given only by the minor patient,” to include “any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement.”¹⁰⁰ Even where state law does require parental consent for these services, disclosure to parents is highly restricted. In that case, “the fact of a minor’s application for treatment may be communicated to the minor’s parent, guardian, or other person authorized under State law to act in the minor’s behalf only if” the minor consents in writing, or if the “program director” determines that the minor patient “lacks capacity for rational choice” and that notifying the parents may reduce “a substantial threat” to someone’s “life or physical well being.”¹⁰¹ Therefore, the Nevada statute described above that requires “any physician who treats a minor” for drug or alcohol abuse to “make every reasonable effort to report the fact of treatment to the parent, parents or legal guardian within a reasonable time after treatment”¹⁰² may be preempted by federal law in the case of a substance abuse patient record covered by the confidentiality rule. The federal confidentiality rule explicitly states that “no State law may either authorize or compel any disclosure prohibited by these regulations.”¹⁰³

The second special case in which military healthcare providers are not bound by state law dictating disclosure of a minor’s protected health information to a parent or guardian is implicated when the MTF has a “reasonable belief” that the situation entails potential abuse, neglect, or endangerment.¹⁰⁴ This provision of the Privacy Rule is applicable not only to minors, but also in all other cases of suspected domestic violence or abuse. Nevertheless, this failsafe provision has “different implications for minors, specifically with regard to disclosure of information to parents.”¹⁰⁵ The MTF “may elect not to treat a person as the personal representative of an individual” with respect to accessing and disclosing that individual’s protected health information, if there is a history of or potential for “domestic violence, abuse, or neglect by such person”;¹⁰⁶ if “treating such person as the personal representative could endanger the individual”;¹⁰⁷ or if “the exercise of professional judgment” leads the MTF to conclude that “it is not in the best interest of the individual to treat the person as the individual’s personal representative.”¹⁰⁸

Conclusion

From a practical standpoint, the inevitable uncertainty in many cases over whether care rendered to minors without parental consent can ultimately be kept confidential from their parents reinforces the importance of doctor-patient communication. This is especially true when setting a minor’s expectations for secrecy, as well as when urging parental involvement where appropriate. For example, Air Force healthcare providers are instructed to “make every effort to encourage the patient to inform parents of their medical issues” whenever minors consent to their own care.¹⁰⁹ This requirement mirrors AMA policy, which states that “when minors request confidential services, physicians should encourage them to involve their parents.”¹¹⁰ Moreover, because parents ordinarily can obtain “access to a minor child’s medical record,” Air Force regulation mandates that “the minor shall be made aware that any care they receive may be discovered.”¹¹¹ The AMA similarly “urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be

⁹⁶ Gudeman, *supra* note 93, at 29.

⁹⁷ U.S. DEP’T OF ARMY, REG. 600-85, THE ARMY SUBSTANCE ABUSE PROGRAM (2 Feb. 2009) [hereinafter AR 600-85].

⁹⁸ U.S. DEP’T OF AIR FORCE, INSTR. 44-121, ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT) PROGRAM (26 Sept. 2001) [hereinafter AFI 44-121].

⁹⁹ Gudeman, *supra* note 93, at 29.

¹⁰⁰ 42 C.F.R. § 2.14(b) (2002).

¹⁰¹ *Id.* § 2.14(c)–(d).

¹⁰² NEV. REV. STAT. ANN. § 129.050 (2003).

¹⁰³ 42 C.F.R. § 2.20.

¹⁰⁴ DoDD 6025.18R, *supra* note 1, para. C8.7.5.

¹⁰⁵ English & Ford, *supra* note 81, at 81.

¹⁰⁶ DoDD 6025.18R, *supra* note 1, para. C8.7.5.1.1.

¹⁰⁷ *Id.* para. C8.7.5.1.2.

¹⁰⁸ *Id.* para. C8.7.5.1.3.

¹⁰⁹ AFI 44-102, *supra* note 6, para. 2.6.1.

¹¹⁰ CONFIDENTIAL CARE FOR MINORS, *supra* note 88.

¹¹¹ AFI 44-102, *supra* note 6, para. 2.6.1.

abrogated.”¹¹² The Society for Adolescent Medicine “suggests that providers clarify to their adolescent patients the circumstances that could lead them to reveal sensitive information to a responsible adult.”¹¹³

Thus, the communication challenge for healthcare providers remains twofold: (1) facilitating interaction “between adolescent patients and their parents in a way that is respectful of adolescents’ need for privacy and the support that parents can provide,” and (2) clearly “conveying the protections and limitations of confidentiality to adolescent patients and their parents.”¹¹⁴ The peculiar challenge facing members of the MHS in this regard is that military providers are bound to practice in several states over the course of a career, and the state where they are providing care at any given time is typically not one where they received their training or are licensed to practice outside the MTF. The intricacies and variations of state law with respect to consent and confidentiality for minors are therefore particularly daunting in the military context. As one attorney specializing in adolescent health issues has summarized the legal landscape:

A handful of states grant minors a right to confidentiality in almost every service to which the minor can give consent. Other states grant minors a right to confidentiality in certain minor consent-granted services, but not others. Alternatively, some states grant providers the discretion to decide when to notify parents about a minor’s services, but parents have no absolute right to the information.¹¹⁵

State laws mandating disclosure are relatively rare compared to those that merely authorize it or allow for physician discretion,¹¹⁶ but where they exist, they can have the effect of essentially tying the healthcare provider’s hands.

The irony from a public policy perspective is that the statutory exceptions to parental consent are largely intended to remove barriers to minors seeking treatment, yet most experts agree that confidentiality is a key to meeting that goal.¹¹⁷ Studies have effectively shown that mandatory parental notification tends to reduce minors’ willingness to seek care but does not significantly alter the underlying behavior, such as sexual activity, that renders such care especially important.¹¹⁸ There appears to be a general consensus within the adolescent healthcare field that “many teenagers would not get treatment if they knew their parents would be notified,”¹¹⁹ and that after-the-fact disclosure, by undermining teens’ readiness “to consent to services in the first place,” can render the right to consent practically “meaningless.”¹²⁰ “The bottom line,” according to some advocates, is that “if we don’t assure access to confidential healthcare, teenagers simply will stop seeking the care they desire and need.”¹²¹ The AMA has opined that “confidential care for adolescents is critical to improving their health,” and thereby advocates eliminating “laws which restrict the availability of confidential care.”¹²²

While some states, such as California, Montana, and Washington, have taken steps to more directly link the right of minors to consent to healthcare services with their right to control the information produced by those encounters,¹²³ the general state of the law in this area remains uneven and highly variable. Military medical providers, and those of us who advise them, must be prepared to encounter this fluctuating terrain and ensure that minors seeking confidentiality are provided with accurate, localized information. It may indeed be the case that “adolescents and the professionals who provide their healthcare have long expected that when an adolescent is allowed to give consent for healthcare, information pertaining to it will usually be considered confidential.” While the law “sometimes supports this understanding,” other times it does not.¹²⁴ To earn the trust of minor patients and avoid misleading them, it is important that MTFs not make promises they cannot keep.

¹¹² AM. MED. ASS’N, HEALTH AND ETHICS POLICY H-60.965, CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS (1992) [hereinafter CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS].

¹¹³ Weisleder, *supra* note 87, at 145–46.

¹¹⁴ English & Ford, *supra* note 81, at 81.

¹¹⁵ Rebecca Gudeman, *Adolescent Confidentiality and Privacy Under the Health Insurance Portability and Accountability Act*, 24(3) YOUTH L. NEWS 1, 2 (July–Sept. 2003).

¹¹⁶ English & Ford, *supra* note 81, at 82.

¹¹⁷ See Ann Maradiege, *Minors’ Rights vs. Parental Rights: Review of Legal Issues in Adolescent Health Care*, 48(3) J. MIDWIFERY & WOMEN’S HEALTH 170–77 (May–June 2003).

¹¹⁸ Diane M. Reddy et al., *Effect of Mandatory Parental Notification on Adolescent Girls’ Use of Sexual Health Care Services*, 288(6) J. AM. MED. ASS’N 710–14 (14 Aug. 2002).

¹¹⁹ Schlam & Wood, *supra* note 22, at 167.

¹²⁰ Dailard, *supra* note 62, at 7.

¹²¹ Boonstra & Nash, *supra* note 36, at 8.

¹²² CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS, *supra* note 112.

¹²³ Rosenbaum, *supra* note 4, at S118.

¹²⁴ English & Ford, *supra* note 81, at 82.