



TEENAGERS, HEALTH CARE, AND THE LAW:

A Guide To Minors' Rights
in New York State

The New York Civil Liberties Union in collaboration
with The Lowenstein Center for the Public Interest
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INTRODUCTION

Adolescents often do not get the health care they need.¹ Research over decades has confirmed that one major barrier is adolescents' fear that health care providers will disclose confidential information about sensitive issues to their parents or guardians.² But in many situations, the law allows teenagers to obtain medical treatment – including “sensitive” health care, such as reproductive or mental health services – without their parents' involvement or even knowledge.

This booklet seeks to clarify teenagers' rights under New York State 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 – 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 generally 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 – such as parents and guardians – can consent when a minor can't. Section II also discusses adolescents who are married, pregnant, parents, emancipated, or incarcerated and therefore may have the right to make some or 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.

In specific areas of health care, 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, sexually transmitted infections (STIs), HIV and AIDS, sexual assault, substance use, and mental health. This section also discusses transgender-related health care, although minors usually cannot consent to this on their own.

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

Section VI provides an overview of public health 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 get the health care they need and deserve.



I.

BASIC DEFINITIONS

Who 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. 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.

Who Is an Adult?

Legally speaking, the term “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, patients must have the *capacity to consent*, meaning they must understand:

- Their 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. Adults are generally presumed to have the capacity to consent.⁶

A health care provider must obtain informed consent before providing medical treatment, unless it would not be reasonable to do so, as is the case in some emergencies.⁷ Consent may be given orally or through the use of a written form, and may sometimes be inferred from 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 (subject to exceptions)⁹ 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.¹¹ Accordingly, 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 a treatment the patient has declined.

Q George is an adult with cognitive impairments. 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, the doctor can treat George based on George's own consent, unless a court has appointed someone else to make health care decisions for George. If the doctor believes George lacks the ability to give informed consent, the law sets out a procedure to follow to ensure that George can still get the care he needs.¹²

What Is Confidentiality?

Confidentiality, with regard to health care, means that information about treatment, such as medical records, cannot be disclosed or released without the permission of the person who consented to the care.¹³

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.

A health care provider must obtain informed consent before providing medical treatment, unless it would not be reasonable to do so, as is the case in some emergencies.



II.

CONSENTING TO HEALTH CARE

Minors and Consent

A minor's right to consent to health care depends on two distinct questions. First, does the minor have the **legal right** to consent, either because the minor is part of a group to whom the law gives this right (e.g., married minors, minors who are parents, minors in the military) or because the minor is seeking a type of health care for which the law allows a minor to give independent consent (e.g., reproductive health care, certain mental health services)? Second, does the minor have the **capacity to consent**, meaning the maturity and intelligence to assess the risks and benefits of proposed treatments and alternatives, so as to give informed consent? These two aspects of consent together are prerequisites to the treatment of minors based on their own decisions. **In order to authorize treatment independently, a minor must have both the legal right to consent and the capacity to give informed consent.** If either of these is missing, the consent of a legally responsible adult will be necessary.

This booklet focuses mainly on a minor's legal right to consent. When a passage says minors "can consent" or "can make their own health care decisions," it means that the minor has the legal right to consent. Remember, however – whether this is separately mentioned or not – that the minor must also have the capacity to consent before independently authorizing health treatment.

There is no minimum age requirement for giving informed consent. Some young minors may have the capacity to consent, while older minors may not. When a minor is consenting on his or her own, a health care provider should document in the medical record how the provider determined the minor's capacity to consent.

Under New York law, the following categories of minors may legally consent to all, or much, of their own health care:

- Pregnant teens,
- Minors who are parents,
- Married minors,
- Minors serving in the armed forces,
- Emancipated minors, **and**
- Incarcerated minors.

In addition, a minor who understands the risks and benefits of proposed and alternative treatments can consent to the following types of care:

- Reproductive health care, including family planning (i.e., birth control, including emergency contraception), abortion, pregnancy/prenatal care, care during labor and delivery, and testing and treatment for sexually transmitted infections, including HIV;
- 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.

When treating minors who do not fit into one of the categories described above or when providing other types of care, health care providers must ordinarily obtain parental consent.

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 has the legal right to consent to health care for sexually transmitted infections. So long as Dana has the capacity to consent, meaning that she understands the risks and benefits of the proposed and alternative treatments, parental consent is not required.

Adults Who Can Consent on Behalf of a Minor

When a minor cannot consent to medical care, the minor can obtain services only with the consent of another person, such as a parent or guardian who can lawfully give such consent.

The following adults may consent to health care for a minor.

Parents

Generally, parents have the right to make medical decisions for their minor children.¹⁴ A parent retains this right even when the parent has decided voluntarily to place the child in foster care.¹⁵ Alternatively, a parent whose child is voluntarily placed in foster care may (but need not) delegate medical decision-making authority to the local commissioner of social services.¹⁶

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

A Because she has voluntarily placed Eric in foster care, Patricia can consent to her son's medical treatment, or she could delegate the responsibility for consenting to his care to the local commissioner of social services.

Guardians and Parental Designees

When a minor has a legal guardian, the guardian may consent to the minor's health care.¹⁷ Also, a parent may designate another person as a "person in parental relation" to a minor for a period not exceeding six months. Such a designee may consent to a minor's health care, subject to certain limitations.¹⁸

The Commissioners of Health or 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.¹⁹

Q Sisters Jayna and Delia have been removed from their parents based on a judicial finding of neglect and placed in foster care. Neither of the girls has ever had dental care, and both need cavities filled. Who can consent to this treatment?

A Because a court has placed the children in foster care, the local social services commissioner or health commissioner can consent to dental care for Jayna and Delia.

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 a parent’s written authorization to consent to the child’s care – may consent to a child’s vaccination,²⁰ 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, unless they have reason to believe that his parents would object.

The human papilloma virus (HPV) vaccine is an exception. Minors may consent to this vaccine on their own.²¹

Legal Status and Minors' Rights to Consent to Care

New York law grants certain minors the right to consent to all or most health care for themselves. This is true, for example, when a minor is married, pregnant, parenting, serving in the military, or otherwise emancipated. 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

Minors who are or have been married may consent to their own medical, dental, health, and hospital care without the consent of any other person.²²

Minors Who Are Parents

In New York State, parents, regardless of age, may make *all* decisions relating to medical, dental, health, and hospital services for themselves²³ and their children.²⁴

Q Rosa, who is 16, 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 medical services for herself and her child.

New York law grants certain minors the right to consent to all or most health care for themselves. This is true, for example, when a minor is married, pregnant, parenting, serving in the military, or otherwise emancipated.

Pregnant Minors

A pregnant minor can consent to medical, dental, health, and hospital services relating to prenatal care.²⁵ No court has explained the scope of services that may be considered “relat[ed] to prenatal care.” Given the courts’ long-standing deference to physicians in such matters,²⁶ however, it is safe to assume that if a physician or other qualified health care provider concludes, in the exercise of sound professional judgment, that a service is related to prenatal care, the provider may offer the service based on the minor’s consent.

Q Priti, who is 15 and pregnant, develops serious dental problems during her pregnancy. May Priti consent on her own to dental care?

A If Priti's dentist concludes that her dental problems are related to her pregnancy (as is often the case), the dentist may treat Priti based on her own consent.

Emancipated Minors

While there is no statutory definition of “emancipation” in New York, courts have defined “emancipation” as “the renunciation of legal duties by a parent and the surrender of parental rights to a child.”²⁷ Parents in this state have a continuing responsibility to support their child financially until the child reaches the age of 21, unless the child has become emancipated before turning 21.²⁸ Once a child is emancipated, the parent no longer has an obligation to support the child.²⁹

Under the common law, emancipation occurs when the minor:

- Attains economic independence from his or her parents through employment;
- Enters into military service;
- Marries; **or**
- Withdraws, without cause, from parental supervision and control, in which case a court may decide that “constructive emancipation” has occurred.³⁰

When a minor is married or serving in the military, New York State law makes clear that the minor is emancipated and may therefore consent to health services independently. When a minor has been constructively emancipated or has attained economic independence, however, a health care provider may require proof of emancipation. In these circumstances, youth legal services organizations, such as The Door (<https://www.door.org/>), assist minors in preparing letters of emancipation, whereby minors attest to living apart from their parents and supporting themselves.³¹ These letters set out the factual basis for constructive emancipation, and health care providers may be willing to treat a minor who presents such a letter based on the minor’s own consent.³² Note, however, that these letters of emancipation are not legally binding; it remains in the discretion of the health care provider to decide whether to treat a minor based on such a letter, and a court could later conclude that the minor was in fact constructively emancipated, or not.³³

Q Ron, 17, has been living on his own for two years. He is financially self-supporting and lives in an apartment with roommates. He is not in regular communication with either of his parents. He has had serious allergies all his life and has recently learned that his chronic congestion is aggravated by cysts in his sinuses. May Ron consent to surgery to remove the cysts?

A Probably. The doctor could reasonably conclude that Ron is emancipated and therefore entitled to make medical decisions for himself. If the doctor were hesitant, Ron might seek the assistance of an organization that could help him prepare a letter of emancipation to further assure the doctor of his emancipated status.

Incarcerated Minors

Minors who are incarcerated in facilities under the control of the Department of Corrections may generally consent on their own to routine medical, dental, and mental health services. Such care is defined to include “any routine diagnosis or treatment, including without limitation the administration of medications or nutrition, the extraction of bodily fluids for analysis, and dental care performed with a local anesthetic.”³⁴ In addition, incarcerated minors may consent on their own to their immunization against hepatitis B.³⁵ When a court is committing a minor under 18 years old to the Department of Corrections, the judge must ask whether the parents or legal guardian will give the minor permission to consent to routine health care.³⁶ Even if no parent or guardian gives permission, however, the law provides that the court order committing the minor to the Department of Corrections will be treated as giving the minor the right to consent to routine services.³⁷ So long as an incarcerated minor is under 18, a parent or guardian may file a

motion objecting to any routine health service to be provided to the minor based on the minor's own consent.³⁸ The law explicitly recognizes that incarcerated minors retain the right to "consent on [their] own behalf to any medical, dental or mental health service and treatment where otherwise authorized by law to do so" (as with most reproductive health and many mental health services).³⁹ These same rules apply to minors who have been found delinquent and placed with the Office of Children and Family Services, a social services district, or the division for youth.⁴⁰

Mature Minors

While New York grants certain minors the right to consent to health care, as described above, New York courts have not yet declared that every mature minor has such a right. Many states have adopted a "mature minor" doctrine or statute, allowing any minor with the capacity to understand the risks and benefits of proposed and alternative treatments to consent or refuse consent to such treatment.⁴¹ New York has no such statute, and the only court to have directly considered the issue declined to decide whether the mature minor doctrine applies in this state.⁴² While several guidance documents on medical ethics and practice advise practitioners to treat mature minors based on their own consent,⁴³ New York law has not yet followed this path.



III.

CONFIDENTIALITY IN HEALTH CARE

General Confidentiality Rules

Unless otherwise specified by law, a health care provider may not reveal confidential information about a patient without the patient's permission.⁴⁴ When the patient is a minor, the right to control the disclosure of health information generally follows the right to consent independently to the underlying health service that is the subject of the information. **Federal law gives a minor the right to authorize the disclosure of health information if the minor consented to the health service in accordance with state law.**⁴⁵ In addition, when a parent agrees that his or her minor child can have a confidential relationship with a health professional, the minor is entitled to control the health information pertaining to any service provided within the scope of that confidential relationship.⁴⁶ **Generally speaking, therefore, when a minor consents to health care, the information relating to that care may not be disclosed without the minor's permission.**

New York law reinforces this general federal rule in an important respect. State regulations create a Statewide Health Information Network, an electronic information-sharing platform for health care providers, health plans, governmental entities, and others. The state regulations governing the network define "minor consent patient information" as "patient information relating to health care of a patient under 18 years of age for which the patient provided his or her own consent as permitted by law, without a parent's or guardian's permission."⁴⁷ The state regulations go on to say that no entity participating in the Statewide Health Information Network may "disclose minor consent patient information to the minor's parent or guardian without the minor's authorization."⁴⁸ Thus, **in New York, a health care provider, plan, or government entity that participates in the Statewide Health Information Network (as most do or soon will) needs the written authorization of a minor patient before disclosing information to a parent about a health service for which the minor gave legal, independent consent.**⁴⁹

Violation of the federal regulations can result in the imposition of civil monetary penalties (as well as other penalties available under other law) by the agencies charged with enforcement.⁵⁰ Breaches of the rules governing the Statewide Health Information Network can lead to warnings, restrictions on participation in the Network, or fines.⁵¹ Violating other, more general state confidentiality rules constitutes professional misconduct and may be punished by fine, reprimand, or revocation of a license.⁵² Additionally, a patient may sue a health care provider for damages for breaching his or her confidentiality in violation of New York law.⁵³

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 requires or 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** information to a minor patient's parents if the provider determines that disclosure would be detrimental to the provider's relationship with the minor, to the care and treatment of the minor, or to the minor's relationship with his or her parents.⁵⁴
- A provider **may withhold** information from a minor patient's parents if the minor is over the age of 12 and objects to the disclosure. In such cases, the health care provider should rely on his or her judgment as to whether to disclose the information.⁵⁵
- A provider **may withhold** information from a minor patient's parents if (i) the provider reasonably believes the minor is subject to abuse or neglect by the parent, (ii) disclosure could endanger the minor, and (iii) the provider determines in the exercise of professional judgment that it is not in the best interest of the minor to involve the parent.⁵⁶

Q When James turns 13, his pediatrician, Dr. Song, has a talk with him and his mother, and they all agree that James will have a confidential relationship with Dr. Song going forward: James will be allowed to decide, in consultation with Dr. Song, when to involve his mother in health care decisions. When James is 16, he sees Dr. Song about a rash in his genital area that appeared after he started wearing a cup for hockey practice. Dr. Song recommends a prescription for an antifungal cream. James does not want to consult his mother about this. Must Dr. Song get consent from James's mother before prescribing the cream?

A No. Because James' mother assented to the confidential relationship between James and Dr. Song, Dr. Song can rely on James's informed consent and need not get prior consent from his mother.⁵⁷

NOTE: Health care confidentiality rules generally apply only to health care professionals and the individuals they supervise.⁵⁸ These rules do not apply to people who obtain confidential health information in nonprofessional capacities, such as friends, family members, neighbors, and landlords.

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. (See *below*, When Otherwise Confidential Care May Not Be Confidential.)

Schools and Confidentiality

The law governing the confidentiality of school health records is unsettled. Federal and state laws generally give parents the right to access the “education records” of their minor children.⁵⁹ Education records are broadly defined to include those containing “information directly related to a student” and “maintained by an educational agency or institution or by a person acting for such agency or institution.”⁶⁰ The U.S. Supreme Court has interpreted this definition to refer to records kept in a central location or a permanent secure database by “agents of the school, such as teachers, administrators, and other school employees.”⁶¹

It is unclear how this definition applies to health records maintained at a school. Some records, including health screening and immunization records collected and kept as a condition of enrollment, must be disclosed to parents upon their request.⁶² Other records may be subject to mandatory disclosure to parents or not, depending on the context. Given the Supreme Court’s interpretation of the relevant federal law, it appears to make a difference whether the health records at issue are stored in the school’s central files or database and maintained by school employees. **Private medical records, separately maintained by school-based health professionals, may be beyond the reach of the federal law.**⁶³ **School-based health care providers would do well to check with counsel before denying or releasing sensitive health information to parents.** Such providers should also let students know whether the information they provide will be kept confidential, and students should ask about confidentiality protections, especially if they have particular concerns in this regard.

In-school programs aimed at preventing or treating drug and alcohol abuse are in a special category. Those subject to federal regulation or receiving federal assistance (whether directly or indirectly) are

bound by federal confidentiality requirements.⁶⁴ These requirements permit disclosure only with the prior written consent of the patient except in narrow circumstances such as to avert a medical emergency or to comply with a court order.⁶⁵

Other adults with whom a minor may interact at school – such as teachers, guidance counselors, social workers, and coaches – are not necessarily required to keep conversations confidential. However, professional ethics and student privacy rights weigh against disclosing to third parties highly personal information, such as information about a student’s pregnancy, sexual orientation, or mental health.⁶⁶ As with other licensed health professionals, school health care

Some records, including health screening and immunization records collected and kept as a condition of enrollment, must be disclosed to parents upon their request.

providers who reveal confidential information without permission may be subject to professional discipline and may also be sued for illegal disclosure.⁶⁷ Schools that disclose confidential student records without the written consent of the student’s parents also face loss of federal funding.⁶⁸

Q **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?**

A **The nurse may and, on their request, probably must disclose the information to Phuong's parents because of their rights to access their child's "education records," including those health records maintained in a central school location or database by school employees. However, the medical information should not be disclosed to the principal without Phuong's parents' consent.**

Q **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 **The professional obligation to maintain the confidences of clients would normally prevent the social worker from reaching out affirmatively to inform Jessi's parents, but if the social worker makes notes of the information, which are then stored in the school's permanent files, Jessi's parents would probably have a right to view those records.**

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 health professionals. Depending on the circumstances, however, disclosure might violate professional ethics and/or the student's privacy rights. It would be best for the teacher to talk to the student about whether she has the support of her parents or other adults regarding the pregnancy. If the student needs additional support, the teacher might work with her to approach social workers, counselors, or others trained to advise students in such situations.

Some schools reach beyond their disclosure obligations to create policies that compromise students' confidentiality. For example, some schools ask school nurses, psychologists, and social workers to report a student's pregnancy to her parents and/or school officials.⁶⁹ Such policies put school-based health care providers at risk of committing professional misconduct by affirmatively revealing students' confidential communications. A school-based health care professional asked to do this should consult with an attorney.

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,⁷⁰ and in other situations, a provider may be compelled to reveal a confidential communication in a legal proceeding.

This section identifies some of the situations in which 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.⁷¹

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 “mandated reporters” – including health care providers and school officials⁷² – 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),⁷³ or other person legally responsible for the child’s care.⁷⁴** A mandated reporter who works in a school, institution, facility, or agency must personally report suspected child abuse to the State Central Register and immediately inform the director of his or her place of employment.⁷⁵ 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 abuse⁷⁶ or neglect⁷⁷ if the caregiver directly harms a child or acts in a way that allows⁷⁸ 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 trigger an investigation only 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 legally responsible for the minor's care.

When a mandated reporter has a reasonable suspicion of child abuse, a failure to report can lead to liability.⁷⁹ In contrast, the law immunizes mandated reporters from liability when they make a report in good faith, without willful misconduct or gross negligence.⁸⁰

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, not to the Central Register.⁸¹

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

Some health care providers have questioned whether they must make a report of child abuse or neglect when they learn that a parent is aware of and has not taken steps to prevent an underage patient's voluntary sexual activity.

These questions arise because the law provides that caregivers who allow a sexual offense to be committed against a child may be considered abusive.⁸² 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 consensual.⁸³ Therefore, when parents know that their underage child is having sex and do nothing to stop it, the question is whether the parents are "allowing" a sexual offense to be committed against their child.

New York courts have declined to give the child abuse statute so broad and untenable a reading, refusing to countenance child abuse charges against the parents of every sexually active minor in the state.⁸⁴ Instead, **the courts have concluded that an abuse charge based on underage sexual activity "must be limited to those parents**

who fail to intervene in forced sexual relationships of which they have personal knowledge.”⁸⁵ 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. Of course, this does not apply where the teenager is having sexual relations with a family member or where the sex is coerced.

Mandated reporters should try to understand the circumstances that led to a younger minor’s pregnancy, STI, or other indication of sexual activity. A report of child abuse or neglect is warranted where the minor was coerced to have sex or subjected to sexual abuse, and a parent or other caregiver knew or should have known of the coercion or abuse and did not take reasonable steps to prevent it. Where the minor is immature and the minor’s more mature sexual partner seems to wield outsize influence or power over the minor, a health care provider may conclude in the exercise of appropriate professional judgment that the relationship is coercive or abusive. In that case, a parent’s acquiescence to the relationship would be reportable. A report based on a parent’s assent to a minor’s consensual sexual activity is unwarranted, however, if the minor’s sexual relationship is voluntary.

Q Daniel, who is 16 years old, is planning to make an appointment with a clinic to check for STIs. He is sexually active with his boyfriend, who is 19. Should Daniel be concerned that the clinic might report his case to child protective services because he is technically a victim of the crime of sexual misconduct?

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

Q Must Daniel reveal his boyfriend's name if his health care provider asks?

A No. Daniel can keep this information private.

Q What if a minor who is a few years younger than Daniel 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 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 another person.⁸⁶ However, notification is not mandatory.⁸⁷

Court Proceedings

As a general rule, health care providers may not disclose confidential medical information without the patient's consent. This rule extends to court proceedings, protecting health professionals from having to testify about confidential information they receive from their patients or clients. Such testimonial privileges apply to communications between a patient and a physician, registered professional nurse, licensed practical nurse, dentist, podiatrist, chiropractor,⁸⁸ psychologist,⁸⁹ social worker,⁹⁰ rape crisis counselor,⁹¹ medical corporation, professional service corporation, or university faculty practice.⁹² However, even these providers may be compelled to testify in court or release confidential records in connection with child abuse or neglect proceedings⁹³ and when a patient under the age of 16 has been the victim of a crime.⁹⁴

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.⁹⁵ In fact, making a police report without the patient's consent would violate confidentiality and constitute professional misconduct.⁹⁶

Confidentiality Among Health Care Providers and in the Insurance and Billing Process

When information is shared among health care providers or between providers, health plans, and insured individuals, confidentiality can be compromised. Problems can arise, for example, when parents seek access to their children's electronic health records for a permissible purpose, but the records include

what should be confidential information; breaches can also occur when bills or explanations of benefits are sent home.

Under New York law governing the Statewide Health Information Network – which permits the sharing of electronic health records among providers, insurers, government agencies, and others – parents may authorize participants in the Network to view minors’ health records.⁹⁷ Parents have this authority *even when a minor’s health record pertains to confidential health services to which the minor consented and even though parents themselves are not permitted to review such records without the minor’s authorization.*⁹⁸ The regulations include exceptions for minors who are emancipated and when federal or state law or regulation requires the minor’s authorization for the disclosure.⁹⁹

The federal HIPAA regulations, in contrast, prevent parents from authorizing the release of a minor’s health care information and give that right instead to minors themselves when the information pertains to a service to which the minor gave independent legal consent.¹⁰⁰ It would seem that the federal regulation entitling minors to control health information about services to which they have consented requires the minor’s authorization for disclosure of the information to Network participants, and that the federal regulation therefore overrides the New York regulation entitling parents to authorize such disclosures. **Despite the NY regulation, therefore, it would be advisable for providers to get the consent of the minor before disclosing to Network participants health information pertaining to a service to which the minor gave independent, legal consent.**

This situation is confusing enough that mistakes may well occur.

Q Jade's father has given Jade's pediatrician, Dr. Samed, written authorization to access all health information in the Network about Jade. Under the New York regulations, this general authorization appears to be sufficient to enable Dr. Samed to see records about Jade's visit to a reproductive health clinic to be tested and treated for an STI, even though Jade consented to that service and her father is not supposed to see the related information. If Jade's family is moving to another state, and her father asks Dr. Samed for a paper copy of Jade's entire health record to give to her new pediatrician, should Dr. Samed turn over the records?

A Not in their entirety. Dr. Samed has an obligation not to give Jade's father the part of the record pertaining to the STI treatment to which Jade consented. But because that information is part of Jade's lifelong medical record, because the New York regulations appear to give Dr. Samed access to that record based on Jade's father's general consent, and because the regulations include no mandatory provisions for segregation or special treatment of sensitive health information,¹⁰¹ the STI record could inadvertently end up in the hands of Jade's father.

A minor’s best workaround may be to ask providers of sensitive services in fields such as reproductive health, mental health, and substance abuse treatment if their patient information can be kept out of the Statewide Health Information Network. The New York regulations allow, but do not require, the “qualified entities” that manage the Network to provide a means for patients to withhold their health information.¹⁰² If a minor sees a health care provider whose “qualified entity” offers this option, it may be possible to keep confidential information out of the Network.

Minors seeking care through the Medicaid program face other issues with regard to electronic information sharing; these issues are discussed more fully in the public insurance section of this booklet (Section VI).

The medical billing process can also lead to breaches of confidentiality,¹⁰³ and these breaches may affect young adults because New York law permits parents to cover their otherwise uninsured children up to age 29.¹⁰⁴ Billing practices can lead to unintended disclosures in a number of ways. For example, a state law requires managed care plans to notify the patient in writing and by phone regarding initial coverage determinations as to services that require preauthorization.¹⁰⁵ 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, a provider can:

- Refer a minor patient for free care when available and advise the minor that the referral may ensure confidentiality that might otherwise be breached in the billing process;

-
- 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; federal and state regulations mandate that health care providers honor reasonable requests to alter the manner in which the provider communicates with the patient, and require insurance companies to honor requests to send information to a different address if disclosure of the information could endanger the patient;¹⁰⁶
 - Request that an insurance plan require prenotification instead of preauthorization for a procedure, thereby avoiding mandatory calls and mailings to the household;
 - 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.

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

- Ask providers whether treatment bills, lab bills, or other documents will be sent home;
- Discuss using an alternative contact address for the purposes of such documents; and
- 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 and the care is confidential. 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 HEALTH
CARE THAT MINORS
CAN RECEIVE
WITHOUT PARENTAL
CONSENT**

Birth Control

Birth control is used to prevent pregnancy and to address a variety of health conditions. Contraceptives come in many different forms, including hormone-based birth control pills, intrauterine devices, implants, shots, condoms, diaphragms, and spermicides.

Consent and Access

A minor may consent to confidential contraceptive services and prescriptions without parental involvement. The federal constitutional right to privacy underlies the right of adults to receive confidential contraceptive services.¹⁰⁷ The U.S. Supreme Court has extended this privacy right to minors in matters relating to the use of contraception.¹⁰⁸ For this reason, the government cannot restrict a minor's access to contraception without a compelling reason.¹⁰⁹ There are no such restrictions under New York law. Therefore, **a minor's right to confidential contraception without parental notification or consent is protected in New York.**

Moreover, when a minor's health care is publicly funded, his or her access to contraceptive services is further protected. Two federal programs require that family planning services and supplies be provided confidentially to all eligible recipients, including sexually active minors: Medicaid¹¹⁰ and Title X of the Public Health Service Act.¹¹¹ Thus, if a clinic or hospital receives funding under either of these programs, it must offer a broad range of contraceptives to minors based on their own consent.

Even when a court places a minor in a religiously affiliated foster care agency, the minor must be given access to reproductive health information and services, including contraception.¹¹²

Confidentiality

As discussed above, a minor is entitled to confidential family planning services without parental involvement.¹¹³

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.¹¹⁴

Q A 14-year-old girl, Carla, wants to get a prescription for birth control pills. Does she need parental consent?

A No. Prescription contraceptives, like all other forms of contraception, must be made available based on the independent consent of a minor with the capacity to understand the risks and benefits of the prescribed drug and its alternatives.

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. Neither federal nor state funding may be used for the sterilization of anyone under 21 years old.¹¹⁵ Further, in New York City, sterilizations may not be performed on anyone under 21 years of age, regardless of the funding source.¹¹⁶ These restrictions reflect the permanent nature of sterilization and mitigate the risk of past abuses that involved the involuntary sterilization of women of color, poor women, and women with disabilities.¹¹⁷

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 it is not the same as a drug known as mifepristone (RU-486), which is taken to induce abortion during the first several weeks of a pregnancy. Most types of EC are effective when taken within 72 (sometimes up to 120) hours after unprotected sex, with effectiveness varying by brand and type.¹¹⁸ As a rule, the sooner EC is taken following unprotected sex, the more successful it is in preventing pregnancy.

To facilitate fast access to EC, the American College of Obstetricians and Gynecologists urges doctors to provide advance prescriptions for EC to patients during routine gynecologic visits.¹¹⁹

Purchasing Emergency Contraception

In April 2013, the FDA approved certain types of EC for sale to people over the age of 15 without a prescription. Following litigation, the FDA revised this approval to include all minors of childbearing age.¹²⁰ Minors can also obtain certain types of EC directly from family planning clinics and other providers across the state.

Emergency Contraception, Medicaid, and Title X

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 EC from a pharmacist.¹²¹

Also, Title X – a federal program that gives grants to support family planning and other preventive services – requires grantees to include a broad range of acceptable and effective family planning methods.¹²²

Title X guidelines further advise providers to offer the full range of FDA-approved contraceptive methods.¹²³ Based on these guidelines, many Title X clinics offer EC on the same basis as any other safe and effective family planning method.

Emergency Contraception and Rape Crisis Care

The New York State Public Health Law requires every hospital providing emergency treatment to a survivor of sexual assault to provide prompt written and oral information about EC, and to provide EC when requested.¹²⁴

Consent

Because EC is a method of contraception, it is available to all minors without the consent of a parent.¹²⁵

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.¹²⁶

Abortion

Various methods of abortion are available depending upon the stage of pregnancy, the patient's preferences, and other medical indications. Abortions by all methods have low complication rates.¹²⁷ Patients should talk to their providers about which method of abortion is best for them.

Consent

A minor in New York can obtain an abortion without parental involvement. The U.S. Supreme Court has ruled that a state may require parental involvement in a minor's abortion decision if the

state also provides an alternative procedure for the minor to seek authorization from a court.¹²⁸ But New York State does not require parental consent or notification. 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 forbids the release of medical records pertaining to a minor's abortion to the minor's parents without explicit consent from the minor.¹²⁹

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,¹³⁰ and those who do not often have compelling reasons including, among others, a reasonable fear of abuse or of exacerbating already strained family situations.¹³¹

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 who provides informed consent can be tested or treated for a sexually transmitted infection without a parent's or guardian's consent.¹³²

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 by diagnosis, prescription, or surgical treatment, physicians may treat adolescents for STIs without parental consent. So long as Tanya has the capacity to provide informed consent, the doctor may not disclose information about STI services to her parents without her permission.

Confidentiality

New York and federal law expressly forbid the release of information about STIs to parents or guardians without the patient's permission.¹³³

Health care providers must, however, comply with New York regulations that require them to report suspected or confirmed cases of communicable diseases. Because New York includes syphilis, gonorrhea, and chlamydia in its list of communicable diseases, physicians must report cases of these STIs to state health officials.¹³⁴ The reporting requirements allow for limited disclosure of personal information only to certain specified state officials.¹³⁵ Moreover, New York law adds special confidentiality protections to reports of

syphilis, gonorrhea, and chlamydia: The state or local departments of health that receive and maintain such reports must keep them confidential, except that very limited disclosure may be permitted to other public health agencies for purposes of disease control.¹³⁶

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 narrow exceptions in the law require disclosure of HIV/AIDS information in limited circumstances (see below).¹³⁷

Consent

A minor who provides informed consent may be tested and treated for HIV/AIDS without a parent's or guardian's consent and may also consent to preventive care to avoid infection.¹³⁸

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. Can a physician treat Raoul without parental consent?

A Yes. A physician may treat Raoul without consulting his parents. However, the physician may want to help Raoul talk to his mother or find a supportive adult in whom he can confide about his situation.

Q Jim and Toni, both minors, are considering a sexual relationship. Jim has been sexually active before and believes he may have been exposed to HIV. Toni has never been sexually active before and wants to prevent exposure to HIV. Can Toni consent to using pre-exposure prophylaxis (PrEP) to avoid infection?¹³⁹

A Yes. A provider can prescribe PrEP based on Toni's own informed consent.

Testing

New York law requires informed consent before an HIV test can be administered.¹⁴⁰ Because the capacity to consent to such testing is determined without regard to age,¹⁴¹ a minor with capacity has the right to consent to – or to refuse – HIV testing. Primary care providers, hospitals, and certain diagnostic and treatment centers are legally required to offer HIV testing to every individual “age thirteen and older (or younger than thirteen if there is evidence or indication of risk activity).”¹⁴²

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.¹⁴³

An individual who decides to get an HIV test 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.¹⁴⁴ Therefore, the results can never be traced to the individual. Anonymous HIV/AIDS testing sites can be located by calling 311 or the regional Anonymous HIV Testing Programs listed in the state and city health department publication, *Say Yes to the HIV Test*, <https://www.health.ny.gov/publications/9678.pdf> (p. 4). All other HIV testing is **confidential**, which means that while the results will largely be kept confidential, they will be subject to reporting and contact notification disclosures (see below).

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 specified circumstances, and only to designated individuals or facilities.¹⁴⁵ In fact, any person who discloses confidential HIV-related information without a signed release under circumstances other than those prescribed by law (see below) is subject to civil and criminal penalties.¹⁴⁶

Special Confidentiality Considerations in HIV/AIDS Care

Disclosure to a Minor’s Parents or Guardians

A person who obtains confidential HIV-related information in the course of providing any health or social service to a minor may disclose such information to the minor’s parent or guardian without the minor’s permission **only if**:

-
- the minor lacks the capacity to consent to the HIV/AIDS services at issue; **and**
 - the parent or guardian is lawfully authorized to consent on the minor’s behalf; **and**¹⁴⁷
 - 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.¹⁴⁸

Even if all the above conditions are met, a physician **may not disclose** confidential information to a minor’s parents if:

- the physician concludes in the exercise of professional judgment that “the disclosure would not be in the best interest of” the minor; **or**
- the minor is otherwise authorized by law to consent to HIV-related care, for example by virtue of marriage, parenthood, pregnancy, or emancipation (see Section II).¹⁴⁹

All decisions regarding parental involvement in a minor’s HIV/AIDS treatment, including the reason for the decision, must be noted in the minor’s medical record.¹⁵⁰

Disclosure to a Minor’s Adoption or Foster Care Agency, Adoptive or Foster Parents, or Attorney

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

When a minor in foster care or awaiting adoption is tested confidentially, but not anonymously, HIV-related information must be released to the following:

- An authorized foster care or adoption agency,¹⁵¹ which must in turn disclose the information to the minor's prospective foster or adoptive parents, or to relatives or other responsible persons who will assume care of the child through official placements;¹⁵²
- An attorney appointed to represent the minor (generally in child abuse or neglect proceedings) insofar as disclosure of the information serves the purpose of enabling the attorney to represent the minor. If the minor is capable of consenting to his or her own health care, the attorney cannot redisclose the information to anyone else without the minor's permission.¹⁵³

Disclosure Pursuant to Written Consent

A patient's general authorization for the release of medical information is **insufficient** to authorize disclosure of HIV-related information. Rather, written consent must specify that HIV-related information is to be disclosed.¹⁵⁴ Disclosure without specific written consent is punishable by a jail sentence or fine.¹⁵⁵

Disclosure Pursuant to a Court Order

Providers may be required by court order to disclose confidential HIV-related information to someone who would not otherwise have access.¹⁵⁶ However, the person requesting the court order must prove extraordinary circumstances to justify the disclosure, and the court must safeguard the confidentiality of the HIV-related information.¹⁵⁷

Tests and Diagnoses of HIV: Reports to the Department of Health Physicians and other designated medical personnel must report to the New York State Commissioner of Health the names of individuals who receive a positive HIV test, a diagnosis of AIDS, or a diagnosis of an AIDS-related illness.¹⁵⁸ In addition, laboratories must divulge the results of other HIV-related tests, regardless of the patient's stage of treatment.¹⁵⁹ The New York State Department of Health cannot disclose any of this information further, except to the extent necessary to conduct contact tracing.

Tests and Diagnoses of HIV: Contact Tracing

A health care provider is also required by law to report to public health officials all known sexual and needle-sharing contacts upon a test or diagnosis.¹⁶⁰ “Known contacts” may include a spouse, boyfriend, or girlfriend, whether the name is disclosed by the patient or known independently by the provider.¹⁶¹ However, **the patient is not required to name any contacts**¹⁶² and cannot be punished or denied treatment for refusing to do so.¹⁶³ Further, although the provider must ask the patient for contact names, the patient is not required to conduct independent research to identify additional contacts.¹⁶⁴

After receiving reports from health care providers, local public health officials determine whether contact notification will protect the public health. If so, the officials are responsible for notifying reported contacts that they may have been exposed to HIV.¹⁶⁵ **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.**¹⁶⁶ However, a contact may be able to figure out independently who triggered the report and notification.

Before making a report to a public health official, a health care provider must screen the patient for signs of domestic violence.¹⁶⁷ The public health official will defer notifying a contact if 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.¹⁶⁸ 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.¹⁶⁹

Q Maya, who is 15, thinks that she might be HIV-positive. She is worried that her boyfriend, Sean, who is 17 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?

A 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 revealing 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.

Q Dr. Johnson has been treating Samuel, 17, for five years. With Samuel's informed consent, Dr. Johnson recently ordered an HIV test 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 Samuel 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?

A Dr. Johnson must report Samuel and any of his contacts who are known to Dr. Johnson. For example, if Dr. Johnson knows Samuel recently got married, she must include Samuel's spouse as a contact in her report. However, Dr. Johnson does not need to perform any additional or independent investigatory work (such as interviewing other people) in order 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.

Ongoing HIV Treatment: Partner/Contact Notification

In addition to the notification requirements associated with tests and diagnoses, a physician has the option of breaching a patient's confidentiality to inform a known contact directly if the physician believes disclosure is medically appropriate and there is significant risk of infection to the contact.¹⁷⁰ However, prior to any disclosure, the physician must take each of the following steps:

- Counsel the individual living with HIV of the need to notify the contact; **and**

- Inform the individual living with HIV of the physician's intent to make disclosure to the contact as well as the physician's responsibility to report the patient's name and the names of contacts to the Commissioner of Health; **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.¹⁷¹

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

A The physician's duty to report contacts to the Commissioner of Health arises at the time of diagnosis of HIV/AIDS or during monitoring that involves laboratory tests; it is not otherwise an ongoing duty.¹⁷² The physician therefore has no duty to report to the Commissioner.

The physician may, however, breach James's confidentiality by telling Colin if medically appropriate and if Colin 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 Colin.¹⁷³ Before making the disclosure, the physician must follow 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.¹⁷⁴ 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.¹⁷⁵

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 discussed above, a minor may authorize or withhold authorization for the disclosure of health information related to any health service to which a minor may lawfully consent.¹⁷⁶ Such information must remain confidential, unless the minor who consented to the health services expressly authorizes the release of that information.¹⁷⁷

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. Assault may involve the use of physical force, emotional coercion, threats, or manipulation. Also, a person may be incapable of giving consent by reason of mental impairment or incapacity (being intoxicated or having passed out, for example). Sexual assault can be violent or nonviolent, and it may or may not involve physical injuries.

What Does Sexual Assault Care Involve?

A person who has been sexually assaulted may seek reproductive health services or treatment for injuries. Sexual assault services involve two components: medical care and evidence collection. **If sexual assault is suspected, hospitals are required to provide, upon request, prophylaxis against sexually transmitted infections and pregnancy (EC), as well as counseling regarding all treatment options so that survivors may make informed choices.**¹⁷⁸ Additionally, hospitals must advise patients of the availability of local rape crisis or victim assistance organizations and, subject to patient consent, contact such organizations on their behalf.¹⁷⁹ Hospitals must also discuss with survivors the option of reporting the offense to the police.¹⁸⁰

The second part of sexual assault care involves what is commonly called the “rape kit,” which is used to collect evidence such as semen, hair, and blood samples for later use if the survivor chooses to file criminal charges.¹⁸¹ Generally, evidence collection is most effective within 72 hours of the assault and before showering. A survivor can choose to receive care where evidence is collected

and then decide later whether or not to file charges. Merely having the examination does not mean the survivor must press charges.

Consent

A minor who is capable of giving informed consent can consent to many aspects of sexual assault care without parental involvement. For example, a minor with capacity may consent to confidential reproductive health services¹⁸² and rape crisis counseling.¹⁸³ Under long-standing Department of Health policy, a mature minor may also consent to the collection and release of forensic evidence related to the assault.¹⁸⁴ In addition, depending on the circumstances, a minor may be able to consent to the treatment of related injuries.¹⁸⁵

A minor who has the capacity to give informed consent for services related to a sexual assault also has the capacity to decline them; thus, no one may force a capable minor to submit to a sexual assault exam.

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 or withholding informed consent to reproductive health care cannot be forced to submit to such an examination. Medical ethics might also preclude the performance of a “virginity test” that has no medical purpose or benefit. Therefore, unless Susan voluntarily consents, the exam cannot take place.¹⁸⁶

Confidentiality

A minor has a right to confidentiality as to some aspects of the care related to sexual assault, but there are important exceptions that may require disclosures in this context.

A health care provider has no general duty to report crimes committed against a patient, and any such reporting, unless required by law, constitutes a confidentiality breach. When a minor is a victim of a sexual assault, however, the law may require disclosures of related information for a range of reasons.

- Health care providers are required to report to child welfare authorities if the circumstances surrounding the assault create a reasonable suspicion of child abuse.¹⁸⁷ For example, a parent or other caretaker may have sexually abused the child or knowingly allowed the child to be coerced into a sexual encounter or relationship.
- If the sexual assault involves gunshot wounds, life-threatening stabbings, or burns, a hospital may be required to turn over evidence of those crimes to the police.¹⁸⁸
- If the sexual assault survivor is under the age of 16, a health care provider or social worker may be compelled to testify in legal proceedings about information gained in the course of treatment that bears on the crime against the minor.¹⁸⁹
- Reporting obligations may also require providers to breach confidentiality when sexual assaults (or other crimes) take place at facilities where patients are receiving mental health care.¹⁹⁰
- Health care providers are required to report to public health officials if the survivor tests positive for HIV, syphilis, chlamydia, or gonorrhea.¹⁹¹

- Because the police are not bound by confidentiality rules, a minor who chooses to file a police report may lose control over how and to whom the information is disclosed.

Q Tracy is 15 and seeks rape crisis treatment after being attacked by a stranger. Besides reproductive health care, such as STI prophylaxis and EC, 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 to treat these other injuries? Can the hospital report the assault to the police?

A It is unclear whether the hospital may contact Tracy's parents to get their consent to treat her bruises and other injuries. Reaching out to her parents could compromise the confidentiality of the array of reproductive health care that Tracy can consent to, but the law does not explicitly grant or deny Tracy the right to consent independently to treatment for her related injuries. The hospital should counsel and encourage her to notify a parent or other responsible adult, if any, who can assist her. The hospital should not, however, contact the police unless it has Tracy's consent and the consent of her parents, if they are involved, except that the hospital is obligated to report certain injuries resulting from gunshots, life-threatening stabbings, or burns.

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. In the outpatient context, a minor's right to consent also depends on the type of facility providing service. The law applies explicitly to "services provided in an outpatient program licensed or operated pursuant to the regulations of the commissioner of mental health."¹⁹² A minor's right to consent is less clear in private, unlicensed mental health settings, and practitioners in such settings may want to consult with legal counsel about how best to offer mental health services to minors.

Outpatient Treatment

A mental health practitioner practicing in a facility licensed or operated by the state Office of Mental Health may provide outpatient services to a minor without parental consent if:

- (1)** The minor knowingly and voluntarily seeks such services, **and**
- (2)** The services are clinically indicated and necessary to the minor's well-being, **and**
- (3)** (i) a parent or guardian is not reasonably available, **or**
(ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment, **or**

- (iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.¹⁹³

Outpatient mental health treatment may include the prescription of psychotropic medications based on a minor's own consent if the minor is 16 or older, the above conditions are met, and the physician obtains second opinions verifying his or her medical judgments.¹⁹⁴ If the conditions outlined above are not present, New York law requires the consent of a parent or guardian for outpatient mental health treatment.¹⁹⁵ 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.¹⁹⁶ A mental health care provider should document in a minor's medical record the basis for a determination as to whether the above criteria are met.¹⁹⁷

Q Qiao-ling is 15. She is severely depressed and wants mental health treatment. She does not want to tell her parents because she believes they will prevent her from seeking care. The physician believes that she needs to be treated. Can the doctor treat Qiao-ling?

A Yes, if Qiao-ling gives her own informed consent to the treatment and the doctor determines that involving her parents would have a detrimental effect on her care. Qiao-ling cannot consent on her own to the use of antidepressants until she turns 16, however, and an independent psychiatrist must verify that she has capacity, the medication is in her best interests, and involving her parents would be detrimental to the course of treatment.

Inpatient Treatment

A minor 16 or over can seek admission to a hospital for inpatient mental health treatment, including medication, on his or her own, but younger teens must obtain parental consent.¹⁹⁸

A minor who is hospitalized for inpatient mental health treatment is ensured access to legal counsel in the following ways:

- The minor, like any other mental health patient, must be informed that legal counsel is available,¹⁹⁹ **and**
- Within three days of the minor's arrival, the facility must give notice to Mental Hygiene Legal Services regarding the minor's admission.²⁰⁰

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.²⁰¹

The court hearing must be scheduled within 72 hours of the date that the facility requests the involuntary commitment.²⁰² 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.²⁰³

As with all other medical services, in an emergency, psychiatric treatment and medication can be made available to a minor without parental consent.²⁰⁴

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

As a general matter, when a minor consents to mental health care, information relating to such treatment may not be disclosed without the minor's permission.²⁰⁵ These confidentiality provisions apply not only to providers licensed by the New York Office of Mental Health, but to any facility in which mental health services are provided, such as psychiatric centers and clinics.²⁰⁶

Even when a parent gives consent to mental health services for a minor, 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 may choose to deny the parent's request.²⁰⁷ A provider is also permitted to deny a parent access to a minor's mental health records upon determining that disclosure would have a detrimental effect on the practitioner's professional relationship with the minor patient, or on the care and treatment of the minor, or on the minor's relationship with his or her parents or guardians.²⁰⁸ Further, professional ethics generally dictate that mental health professionals maintain strict confidentiality in dealing with their patients, including their minor patients.²⁰⁹

There are, of course, exceptions to the general rule of confidentiality. The law permits disclosures pursuant to court order; notifications

to legal service providers; and reports to health oversight agencies, individuals who might be endangered by a patient, researchers, coroners, prisons, other health care providers, and an array of other individuals and entities.²¹⁰ In particular, New York law requires the directors of mental health facilities to notify parents of accidents or injuries that affect the health and safety of a patient and allows parents and guardians access to facility records related to such incidents.²¹¹

In addition, more targeted provisions of the mental health law and regulations require reporting of a wide range of misconduct in or under the auspices of certain kinds of facilities. Facilities operated or funded by the Office for People with Developmental Disabilities,²¹² for example, must disclose to oversight agencies, report to a Vulnerable Persons' Central Register, and notify parents of incidents involving the physical, psychological, and sexual abuse of patients, along with many other acts and omissions that may cause harm.²¹³ The Central Register must, in turn, screen reports and forward those that appear to allege crimes to appropriate law enforcement agencies.²¹⁴ Similar laws apply to facilities and programs operated, funded, or administered by the Office of Mental Health.²¹⁵

Because of these and other reporting obligations, confidentiality protections will vary from case to case depending on many factors, such as where the incident 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 and how general confidentiality rules apply to a particular situation at a mental health care facility.

Alcohol and Substance Abuse Services

Consent

In general, when treating a minor for chemical dependence²¹⁶ on an inpatient, residential, or outpatient basis, health care providers must take steps to involve the parents or guardians in the course of treatment and obtain consent from a parent or guardian.²¹⁷ However, a minor may be admitted for inpatient, residential, or outpatient treatment related to chemical dependence without parental or guardian involvement and consent, if:

- The physician 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 to such treatment, and the physician believes that such treatment is necessary to protect the best interests of the minor;²¹⁸ **or**
- The provider cannot locate the parent or guardian after employing reasonable measures, in which case the program director may authorize the treatment of the minor;²¹⁹ **or**
- The parents or guardians fail or refuse to communicate with the provider within a reasonable time regarding the minor's treatment, in which case the program director may authorize the treatment of the minor;²²⁰ **or**
- The minor is a parent, married, or emancipated.²²¹

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 the minor is voluntarily seeking treatment and has been advised of the availability of help from

the mental hygiene legal service and of his or her rights under the New York Mental Hygiene Law.²²²

When a minor is admitted without parental involvement and consent, the provider must use his or her best efforts to obtain from the minor the name, address, and telephone number of an adult who may serve as an emergency contact. The provider must then verify the existence of the emergency contact, but only after giving notice to the minor and receiving the minor's prior written consent to reach out to the emergency contact.²²³ Note, however, that a facility may admit a minor patient for treatment related to chemical dependence even if reasonable efforts to identify an emergency contact have failed.²²⁴

Confidentiality

When a minor obtains alcohol abuse or substance abuse services at a program or facility receiving funding from any federal department or agency, confidentiality is stringently protected.²²⁵

Disclosure is allowed only pursuant to written consent or a court order, or in a medical emergency.²²⁶ If the minor patient acting alone consented to substance abuse treatment in accordance with the law outlined above, then the minor patient alone has the authority to consent or refuse to consent to a disclosure, including to the minor's parent or guardian.²²⁷ If a parent or guardian provided consent to the minor's treatment, then both the minor and the parent or guardian must consent in writing to any disclosure of related information.²²⁸ If a minor seeks substance abuse treatment in a situation in which New York law requires the consent of a parent or guardian, a program receiving federal funds may notify a parent or guardian of the minor's request only if: (1) the minor consents in writing or (2) the program director concludes that the minor lacks the capacity for rational decision-making, and communication with

a parent or guardian would mitigate a “substantial threat to the life or physical well-being of the minor applicant or any other individual.”²²⁹

The general prohibition on disclosure in federally funded programs is expansive. In the absence of a court order,²³⁰ federal law explicitly bars law enforcement from using information maintained by such a program to initiate or substantiate criminal charges or to conduct an investigation against a patient.²³¹ Moreover, 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.²³²

Q Duane is 16. He is thinking about talking to a school substance abuse counselor about his drinking problem, but he 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 many schools receive federal funding, which subjects any associated substance abuse program to strict consent and confidentiality rules. Whether or not the counselor decides to treat Duane, the counselor may not disclose information to Duane’s parents without Duane’s permission if the school receives federal funds.²³³

If a minor seeks substance abuse treatment in a facility or from a provider that receives no federal funds, New York law guarantees the confidentiality of the associated information in accordance with the many applicable laws shielding health records.²³⁴

Emergency Care

Consent

A doctor may treat a minor without the consent of a parent or guardian when the doctor has determined, in the exercise of professional judgment, that an emergency exists, the minor is in immediate need of medical attention, and an attempt to secure consent from a parent or guardian would result in delay that would increase the risk to the minor's life or health.²³⁵ One New York court has held 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."²³⁶

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. May he receive treatment?

A Yes. The doctor can treat Luis's asthma attack to address his urgent need for care.

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

A 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

When a health care provider treats a minor without parental consent to address an emergency that resulted from accidental injury or the unexpected onset of serious illness, the provider must give the minor's parent or guardian an opportunity, within 10 days, to inspect any patient information relating to such care.²³⁷ The health care provider may, however, deny a parent or guardian access to such information if the provider determines that disclosure would have a detrimental effect on the provider's professional relationship with the minor, on the care and treatment of the minor, or on the minor's relationship with his or her parents or guardian.²³⁸ Furthermore, a health care provider may notify a minor over the age of 12 of a parent's or guardian's request to review his or her information relating to emergency care and may deny access if the minor patient objects.²³⁹

Transgender-Related Health Care

Consent

Youth whose gender identity does not match the sex they were assigned at birth may want health care to confirm their gender identity. **So far, no New York law specifically allows teens to consent on their own to trans-related health services. To the extent that a minor seeks mental health care related to gender identity, however, the general rules granting minors independent access to such care apply.**²⁴⁰ And as with any other health care, a married, parenting, or emancipated minor may consent independently.

Confidentiality

When a parent or guardian consents to trans-related health care for a minor, that parent or guardian also has the right to authorize or refuse the disclosure of information about such treatment. Conversely, when a minor consents independently to the treatment,

based on emancipation, for example, the minor will control the release of information related to the services.²⁴¹

Equal Access to Health Care

New York law prohibits discrimination based on “gender identity, self-image, appearance, behavior or expression.”²⁴² Regulations issued by the state Division of Human Rights provide that discrimination based on gender identity or “the status of being transgender” constitutes sex discrimination.²⁴³ In addition, discrimination based on “gender dysphoria” – a medical condition involving the severe distress that may result from having “a gender identity different from the sex assigned at birth” – constitutes discrimination based on disability; such that individuals with gender dysphoria are entitled to reasonable accommodations.²⁴⁴

Trans children and teens are therefore entitled to be treated like any patient with a health care need when they seek services of any kind, including services related to their gender identity.

Coverage for Low-Income Minors

For low-income teens, Medicaid covers some trans-related health care. Sixteen- and 17-year-olds can qualify for hormone therapy if they meet certain criteria and a qualified medical professional determines that the treatment is medically necessary.²⁴⁵ Minors under 16 can also qualify “in specific cases if medical necessity is demonstrated and prior approval is received.”²⁴⁶ Medicaid will cover gender-confirmation surgery for those who are over 18 and have two letters of referral from mental health professionals; for minors under 18, surgery may be covered “in specific cases if medical necessity is demonstrated and prior approval is received.”²⁴⁷ Children in foster care or in the juvenile justice system in New York City may qualify for trans-related health care even when Medicaid does not provide the necessary coverage.²⁴⁸



V.

MINORS IN
FOSTER CARE

A minor in foster care is entitled to consent independently to the same health care services as any other minor.²⁴⁹ In circumstances in which the minor may not consent on his or her own, parental consent is required if parental rights have not been terminated or surrendered.²⁵⁰ If parental rights have been terminated or surrendered, health care providers may not contact the parents or seek their consent; instead, the foster care agency authorizes health services for the child.²⁵¹

No matter who consents to the treatment, minors in foster care face greater risks than others that their medical confidentiality 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, placed in foster care, or placed with a relative or other legally responsible person.²⁵²

HIV-Related Information

The law gives minors in foster care less protection than others with respect to the confidentiality of HIV-related information.

Providers may release confidential HIV-related information to an authorized foster care agency, without permission, but they are not required to do so.²⁵³ **Foster care agencies, however, must** release any HIV-related medical information of which they have knowledge to prospective foster or adoptive parents, or other responsible persons who will assume care of the child through official placements,²⁵⁴ but must safeguard this information from disclosure to others. Of course, if a minor receives anonymous HIV testing, results will remain confidential.²⁵⁵

Reproductive Health Care

Minors in foster care are entitled to receive health services through their foster care agencies within 30 days of the minor's request.²⁵⁶ Such services include confidential family planning services, such as contraceptive supplies and counseling, and minors in foster care – like all other minors – can consent to such services on their own.²⁵⁷ However, because medical information obtained by foster care agencies is subject to the mandatory disclosure requirements referenced above, in order to ensure full confidentiality, a teen may want to seek care for sensitive health issues from doctors or clinics that are independent from the foster care agency.

Q Clara, who is 16, is in foster care and wants to see a gynecologist to begin annual reproductive care checkups. 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 Clara can seek treatment from an independent health care clinic or provider – such as Planned Parenthood (<https://www.plannedparenthood.org/health-center>), the Community Health Care Network (<http://www.chnny.org/>), or the Mount Sinai Adolescent Health Center (<http://www.mountsinai.org/patient-care/service-areas/adolescent-health-center>) – that is not associated with the foster care agency. Such clinics must keep her medical information confidential and cannot disclose it to foster care agencies without her prior consent. Note, however, that if Clara seeks HIV care, related information will be subject to disclosure, even if the health care provider is not affiliated with the foster care agency.

Transgender-Related Health Care

Medicaid covers hormone therapy for low-income teens who have been diagnosed with gender dysphoria, a medical condition reflecting the extreme distress that can result when a person's gender identity does not match that person's body.²⁵⁸ A minor in foster care or certain juvenile justice placements in New York City may receive broader coverage, however. Even in situations in which Medicaid does not cover the services, the New York City Administration for Children's Services covers "gender affirming healthcare," defined to include "various types of medical care that transgender, transsexual, and gender non-conforming individuals may seek in relation to their gender identity."²⁵⁹ The general guidelines for consent in the foster and juvenile justice systems apply to trans-related care, meaning that parental or agency consent will usually be required.²⁶⁰



VI.

**PUBLIC HEALTH
INSURANCE PROGRAMS
AVAILABLE TO MINORS**

Medicaid

Medicaid is a publicly funded insurance program that covers comprehensive medical services, including prenatal care, abortion, and birth control, for minors who meet income and immigration eligibility requirements.²⁶¹ **A young person may get a list of community-based organizations that can help him or her apply for Medicaid or Child Health Plus (see below) by calling 1-800-698-4KIDS (1-800-698-4543) or going to the New York State Department of Health website: https://www.health.ny.gov/health_care/child_health_plus/where_do_i_apply.htm.**

Eligibility

Generally, minors receive Medicaid services through an eligible parent's Medicaid enrollment. However, some minors who support themselves in their own households or who are married, pregnant, or parenting may apply on their own for Medicaid.²⁶²

Minors can apply independently for Medicaid, without having their parents' income counted as available to them, if:

- The minor is legally married, in which case, only the income of the minor and his or her spouse will count in determining eligibility;²⁶³
- The minor is 16 or older, stayed in school until age 16, does not live with or receive money from a parent or guardian, and does not live in foster care. The government may nevertheless sue the minor's parent(s)/guardian(s) for the cost of the minor's medical care;²⁶⁴
- The minor is 16 or 17, pregnant or a parent, and does not live with the minor's parent or guardian because no parent or guardian is available; the minor and his or her child would be at serious risk of harm if they lived with the minor's parent or

guardian; or it is otherwise not in the best interest of the minor and his or her child to live with the minor's parent or guardian. The government may nevertheless sue the minor's parent(s)/guardian(s) for the cost of medical care for the minor and the minor's child;²⁶⁵

- The young person is 18-20 and pregnant or a parent. Because Medicaid continues to treat anyone under 21 as the dependent of a parent, the government may sue the young person's parent(s)/guardian(s) for the cost of medical care for the young person, but not for the cost for the young person's child;²⁶⁶
- The young person is 18-20, and the parent or guardian is unavailable or cannot or does not offer a safe home for the young person. The government may sue the young person's parent(s)/guardian(s) for the cost of medical care for the young person.²⁶⁷

Medicaid covers pregnant minors (and pregnant adults) at a higher income limit than applies to others. Income-eligibility levels are adjusted annually, but the 2017 threshold was set at \$35,524 a year for a family of two (and a pregnant woman counts as herself plus the number of infants she is expected to deliver).²⁶⁸ The coverage extends to a wide range of pregnancy-related screenings and services and continues during a 60-day postpartum period.²⁶⁹

A newborn whose mother is on Medicaid is automatically covered by Medicaid through the first year of life and should be automatically enrolled.²⁷⁰ The income-eligibility level for babies up to age one is the same as for pregnant women.²⁷¹ 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.²⁷²

Income-eligible pregnant minors (and adults) qualify for Medicaid in New York regardless of their immigration status, meaning that even undocumented minors can get coverage during and immediately following their pregnancies.²⁷³ Like all other infants born to Medicaid-eligible women in the U.S., the native-born children of immigrant mothers are automatically enrolled in Medicaid and eligible for coverage from birth until at least the baby's first birthday.²⁷⁴

Any pregnant woman, including an undocumented woman, who has Medicaid during her pregnancy but who loses Medicaid after the pregnancy ends (for example, because she is no longer eligible or because she fails to reapply) will probably be eligible for 24-26 months of Medicaid-covered family planning services under the Family Planning Extension Program (FPEP). FPEP is available regardless of whether the pregnancy ended in a miscarriage, live birth, stillbirth, or abortion.²⁷⁵

Confidentiality

Medical services provided under Medicaid are subject to special confidentiality protections.²⁷⁶ These protections apply whether the minor is enrolled independently or under a parent's Medicaid.

Confidentiality may be jeopardized, however, when bills, lab reports, or managed care plan 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 a mailing address that is different from their home address so as to avoid confidentiality breaches through billing and other correspondence.²⁷⁷

The Medicaid program also poses confidentiality problems with regard to electronic information sharing. New York Medicaid acknowledges that “[t]here are certain types of care that a minor can consent/agree to without his/her parent’s or guardian’s agreement” and that “[t]he minor has a right to say who can see that information by state and federal law.”²⁷⁸ Yet the Medicaid program is unable to “segregate Medicaid claims information based upon a type of service.”²⁷⁹ Therefore, a minor who wants to protect the confidentiality of health information relating to services to which the minor independently consented must let Medicaid know not to share the minor’s entire health record, as Medicaid does not have the ability to protect discrete parts of the record.²⁸⁰

Child Health Plus

New York’s Child Health Plus (CHP) is a publicly funded insurance program for children and adolescents age 18 and younger.²⁸¹ CHP provides comprehensive health benefits including prenatal care, abortion, and the full range of reproductive health care.²⁸² A minor can get information on applying for CHP by calling 1-800-698-4543 or going to the New York State Department of Health website: https://www.health.ny.gov/health_care/child_health_plus/.

Eligibility

Because CHP has a higher household income limit than Medicaid²⁸³ and is available regardless of an enrollee’s immigration status,²⁸⁴ there is a good chance that if a teen is not eligible for Medicaid, the teen will be eligible for CHP.

Generally, minors need parental participation in order to enroll in CHP. However, married, pregnant, and parenting minors may enroll themselves and their children in CHP without a parent’s or guardian’s participation, and otherwise emancipated minors may also be able

to enroll themselves; minors in these situations would benefit from in-person assistance with the enrollment process.²⁸⁵ A minor may locate nearby individuals qualified to provide in-person assistance at the N.Y. State of Health website: https://nystateofhealth.ny.gov/agent/hx_brokerSearch?fromPage=INDIVIDUAL. Note that those who try to self-enroll must obtain the proper documents to verify household income eligibility.

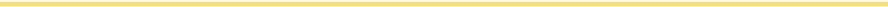
Confidentiality

The medical services provided under CHP are subject to the same confidentiality rules as apply in the Medicaid program.²⁸⁶ Billing may present a confidentiality problem, 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 requires managed care plans to notify a patient in writing and by phone after the plan has made an initial determination of whether and to what extent a health service requiring preauthorization is covered (most surgical procedures require preauthorization).²⁸⁷ Providers can work with their patients to find out what information their managed care plan sends home and to figure out how to avoid unintentional confidentiality breaches. Health plans must make reasonable accommodations for patients whose safety depends on receiving communications by alternative means or at alternative locations.²⁸⁸

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 Program 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.



- ¹ Tumaini R. Coker et al., *Improving Access to and Utilization of Adolescent Preventive Health Care: The Perspectives of Adolescents and Parents*, 47 *J. Adolescent Health* 133, 133–34 (2010) (“[A] substantial proportion of U.S. adolescents does not routinely utilize preventive care; utilization may be especially low among African American youth, Latino youth, and youth living in poverty.”) (footnotes omitted); Kaiser Family Foundation, *Adolescent Health: Coverage and Access to Care*, Women’s Issue Brief, Oct. 2011, at 4 (“Approximately 4 million adolescents ages 10–18 lack health insurance. . . . Adolescents without healthcare insurance or with gaps in coverage have worse access to needed health services, and half of uninsured adolescents have at least one unmet health need.”), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8236.pdf>.
- ² Kaiser Family Foundation, *Adolescent Health: Coverage and Access to Care*, Women’s Issue Brief, Oct. 2011, at 2 (“Research has found that some teenagers will go without care, withhold information about themselves, delay, or not seek help in order to keep their parents from finding out about a health issue. Confidentiality and privacy issues do not only pose significant barriers to successful screening and assessment of risky behavior, but can affect patient compliance and return for follow-up visits after a diagnosis.”) (footnotes omitted), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8236.pdf>; *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 *J. Adolescent Health* 160, 162 (2004) (“In two large national surveys, approximately one-quarter of middle and high schools students reported that they did not seek health care they needed. One of these studies found that 35% of students who did not seek care reported one reason was ‘not wanting to tell their parents.’ . . . [O]ne-half of single, sexually active girls under 18 years of age recently surveyed in family planning clinics in one state reported that they would stop using the clinics under conditions of mandatory parental notification for prescription contraceptives. An additional 12% reported that they would delay or discontinue use of specific services such as services for STIs.”) (footnotes omitted), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Aug-04-Confidential_Health_Care_for_Adolescents.pdf.
- ³ N.Y. Gen. Oblig. Law § 1-202 (McKinney 2017); N.Y. C.P.L.R. § 105(j) (McKinney 2017). **(Note: The dates of all statutory and regulatory citations are drawn from Westlaw rather than from the official published compilations.)**
- ⁴ In fact, children are entitled to child support, subject to the parent’s financial means, until age 21 – even after they are legally adults. N.Y. Fam. Ct. Act § 413 (McKinney 2017).
- ⁵ N.Y. Pub. Health Law § 2805-d (McKinney 2017) (defining lack of informed consent as “the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation”); N.Y. Mental Hyg. Law § 80.03(c) (McKinney 2017) (“Lack of ability to consent to or refuse major medical treatment means the patient cannot adequately understand and appreciate the nature and consequences of a proposed major medical treatment, including the benefits and risks of and alternatives to such treatment, and cannot thereby reach an informed decision to consent to or to refuse such treatment in a knowing and voluntary manner that promotes the patient’s well-being.”).

- ⁶ See N.Y. Pub. Health Law § 2994-c(1) (McKinney 2017) (“For purposes of this article, every adult shall be presumed to have decision-making capacity unless determined otherwise pursuant to this section or pursuant to court order, or unless a guardian is authorized to decide about health care for the adult pursuant to article eighty-one of the mental hygiene law.”).
- ⁷ See *Schloendorff v. Soc’y of N.Y. Hosp.*, 211 N.Y. 125, 129-30 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained.”), *modified in part on unrelated grounds by Bing v. Thunig*, 2 N.Y.2d 656 (1957); *Dale v. State*, 355 N.Y.S.2d 485 (3rd Dep’t 1974), *aff’d*, 370 N.Y.S.2d 906 (1975); see also N.Y. Pub. Health Law § 2805-d (McKinney 2017).
- ⁸ Werner Weinstock & Eve W. Paul, *Medical Treatment of Minors Under New York Law*, N.Y. J. Med., July 1978, at 1297, 1299 § 1:14.
- ⁹ N.Y. Pub. Health Law § 2805-d (McKinney 2017).
- ¹⁰ See *Schloendorff*, 211 N.Y. at 130; *Fogal v. Genesee Hosp.*, 344 N.Y.S.2d 552, 559 (App. Div. 2d Dep’t 1973) (“The cause of action is not based on any theory of negligence but is an offshoot of the law of assault and battery.”); *Darrah v. Kite*, 301 N.Y.S.2d 286, 290 (App. Div. 3d Dep’t 1969) (“It has long been settled in this State that a ‘surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.’”). Modern case law holds that malpractice is the preferred cause of action for addressing lack of informed consent, whereas assault and battery is the proper cause of action in the complete absence of consent in nonemergent circumstances. See *Slandy v. Bryk*, 864 N.Y.S.2d 46, 57 (App. Div. 2d Dep’t 2008) (“[M]edical malpractice is the gist of the wrong when an operation or procedure is performed without the informed consent of the patient to the risks involved. Battery is the cause of action when the patient has not consented at all to the operation or procedure.”) (internal citations omitted); *Spinosa v. Weinstein*, 571 N.Y.S.2d 747, 753 (App. Div. 2d Dep’t 1991) (“[W]e agree that a claim for assault and battery may still be maintained in ‘nonemergent situations involving no consent at all.’”) (citations omitted); *Romatowski v. Hitzig*, 643 N.Y.S.2d 686, 689 (App. Div. 3d Dep’t 1996) (“[W]here medical treatment is rendered with the actual consent of the patient, any alleged lack of informed consent is medical malpractice and not the intentional tort of assault and battery.”).
- ¹¹ See *Cruzan by Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990) (A competent person has a constitutionally protected right to refuse unwanted medical treatment). Note that, because most minors do not have independent legal authority to consent to life-sustaining treatment, they also do not have independent legal authority to refuse it. See N.Y.S. Dep’t of Health, *MOLST/ Medical Orders for Life-Sustaining Treatment, Legal Requirements Checklist for Minor Patients and Glossary 1* (Dec. 1, 2010) (noting exceptions for emancipated minors but stating general rule as follows: “The parent of a minor patient has the authority to make decisions on behalf of the minor about life-sustaining treatment, including decisions to withhold or withdraw life-sustaining treatment. The minor patient must also consent if the minor patient has medical decision-making capacity.”), https://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_minor.pdf; N.Y.S. Dep’t of

Health, Bureau of EMS Policy Statement 99-09, *Patients Care and Consent for Minors* (Nov. 1999) (outlining exceptions for emancipated minors and minors consenting to certain types of services, but stating general EMT protocol as follows: "An individual who is legally a minor cannot give effective legal/informed consent to treatment and therefore, conversely, cannot legally refuse treatment."), <https://www.health.ny.gov/professionals/ems/policy/99-09.htm>.

¹² See N.Y. Pub. Health Law § 2994-c (McKinney 2017).

¹³ New York law recognizes several practitioner-patient privileges, which generally prevent practitioners from being compelled to testify about patient confidences. N.Y. C.P.L.R. §§ 4504(a), 4507, 4508, 4510 (McKinney 2017). These privileges apply when: (1) a provider-patient relationship was established; (2) the information was obtained in the course of treatment; and (3) the information was necessary for treatment. See *Hughson v. St. Francis Hosp.*, 463 N.Y.S.2d 224, 229 (App. Div. 2d Dep't 1983). Moreover, a health care professional who discloses confidential communications without the prior consent of the patient is guilty of professional misconduct. 8 N.Y.C.R.R. § 29.1(b)(8) (2017) ("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 2017) (declaring any unprofessional conduct to be professional misconduct). 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 more extended discussion of a provider's duty of confidentiality, the consequences of breaching this duty, and exceptions to

the general rule of confidentiality, see *infra* Section III.

¹⁴ N.Y. Pub. Health Law § 2504(2) (McKinney 2017) ("Any person who . . . has borne a child may give effective consent for medical, dental, health and hospital services for his or her child."). Except in certain circumstances outlined in this booklet, minors may receive medical treatment only with the consent of their parents or custodians. See *Sombrotto v. Christiana W.*, 852 N.Y.S.2d 57 (App. Div. 1st Dep't 2008) (reversing order that authorized administration of psychotropic drugs to minor patient over parents' objection and reviewing basis of and limitations upon parents' right to direct health care of minor children); *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); *T.D. v. N.Y.S. Office of Mental Health*, 650 N.Y.S.2d 173, 191-93 (1st Dep't 1996) (invalidating regulations that permitted medical research on children without the consent of a parent or guardian); *In re AB*, 768 N.Y.S.2d 256, 270 (Sup. Ct. 2003) (recognizing the parental right to determine or refuse treatment for minor children).

The parent who gives consent will normally be one with whom the child has a close ongoing relationship. Questions sometimes arise, however, about the legal sufficiency of the consent of a biological parent with whom the minor has no real relationship. While there is no case directly on point, the analogous case law suggests that a health care professional should be wary of relying on such consent. See *Hodgson v. Minnesota*, 497 U.S. 417, 437-44 (1990) (detailing the harms of requiring two-parent consent for abortion, especially in families in which one parent is long absent); see also *Lehr v. Robertson*, 463 U.S. 248, 261-62, 266-67 (1983) (holding that an unwed father has no right to notice and consent

to the adoption of his biological child unless he has taken the available opportunities to develop parental bonds to the child). A health professional should consult an attorney or the NYCLU if presented with a case in which a minor patient seeks to rely on the consent of an otherwise absentee parent to authorize medical care.

- ¹⁵ 18 N.Y.C.R.R. 441.22(d) (2017) (“Prior to accepting a foster child into care in cases of voluntary placement . . . authorization in writing must be requested from the child’s parent or guardian for routine medical and/or psychological assessments, immunizations and medical treatment, and for emergency medical or surgical care in the event that the parent or guardian cannot be located at the time such care becomes necessary. Such authorization must become a permanent part of the child’s medical record.”).
- ¹⁶ 18 N.Y.C.R.R. 441.22(d) (2017).
- ¹⁷ See, e.g., *In re 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”), *superseded by statute on other grounds*, N.Y. Surr. Ct. Proc. Act § 1750-b(1) (McKinney 2017) (allowing guardians of adults with intellectual disabilities to decline or withdraw life-sustaining treatment); see also N.Y. Pub. Health Law § 2442 (McKinney 2017) (requiring the consent of a parent or legal guardian in order to include a minor in a medical research protocol).
- ¹⁸ N.Y. Pub. Health Law § 2504(2) (McKinney 2017); N.Y. Gen. Oblig. Law § 5-1551 (McKinney 2017).
- ¹⁹ N.Y. Soc. Serv. Law § 383-b (McKinney 2017); see also 18 N.Y.C.R.R. § 507.1(a) (2017) (requiring the local social services district to provide “comprehensive medical services for children in foster care”); 18 N.Y.C.R.R. 441.22(f), (g) (2017) (detailing services to be provided). *But see In re Martin F.*, 820 N.Y.S.2d 759, 772 (Fam. Ct. 2006) (invalidating N.Y. Soc. Serv. Law § 383-b insofar as it would allow the government to authorize administration of psychotropic drugs to a young foster child without the parent’s consent); *In re Lyle A.*, 830 N.Y.S.2d 486 (Fam. Ct. 2006) (requiring health care providers to obtain a court order before administering psychotropic medication to a child in foster care against the wishes of the child’s parent).
- ²⁰ N.Y. Pub. Health Law § 2504(5) (McKinney 2017). 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. *Id.*; see also N.Y. Pub. Health Law § 2164(1)(b) (McKinney 2017) (defining “person in parental relation to a child” as used in Pub. Health Law § 2504(5)).
- ²¹ N.Y. Pub. Health Law § 2305(2) (McKinney 2017); 10 N.Y.C.R.R. § 23.1 (2017).
- ²² N.Y. Pub. Health Law § 2504(1) (McKinney 2017) (“Any person who . . . has been married may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.”); see also N.Y. Mental Hyg. Law § 22.11 (McKinney 2017) (stating that married minors may consent to treatment for chemical dependence without a requirement to notify the minor’s parents or guardian). Note that under New York law, a person must be at least 18 years old to consent to marry, and marriage is prohibited for those younger than 17, even with parental consent. N.Y. Dom. Rel. Law §§ 7(1), 15-a (McKinney 2017).
- ²³ N.Y. Pub. Health Law § 2504(1) (McKinney 2017) (“Any person who . . .

- is the parent of a child . . . may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.”).
- ²⁴ N.Y. Pub. Health Law § 2504(2) (McKinney 2017) (“Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child.”).
- ²⁵ N.Y. Pub. Health Law § 2504(3) (McKinney 2017) (“Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.”).
- ²⁶ See, e.g., *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (citing cases that establish “the importance of affording the physician adequate discretion in the exercise of his medical judgment”).
- ²⁷ *Zuckerman v. Zuckerman*, 546 N.Y.S.2d 666, 668 (2d Dep’t 1989) (citing *Gittleman v. Gittleman*, 438 N.Y.S.2d 130, 132 (2d Dep’t 1989)); see also *Matter of Bates v. Bates*, 310 N.Y.S.2d 26 (Fam. Ct. Westchester Cty. 1970).
- ²⁸ N.Y. Fam. Ct. Act § 413(1)(b)(2) (McKinney 2017) (“‘Child support’ shall mean a sum to be paid pursuant to court order or decree by either or both parents or pursuant to a valid agreement between the parties for care, maintenance and education of any unemancipated child under the age of twenty-one years.”).
- ²⁹ *Id.*; see also Merrill Sobie, Supplemental Practice Commentaries to N.Y. Fam. Ct. Act § 413, *Emancipation of the Child* (McKinney 2016) (following text of statute) (“The emancipation of the child terminates the parental obligation to support.”). Note, however, that a child may reverse an emancipation and regain a right to parental support by again becoming dependent on a parent. *Baker v. Baker*, 11 N.Y.S.3d 370, 371 (4th Dep’t 2015) (stating that a child’s unemancipated status may be revived provided there has been a sufficient change in circumstances to warrant the corresponding change in status); see also *Hamdy v. Hamdy*, 612 N.Y.S.2d 718 (4th Dep’t 1994) (finding that “permitting reversion to unemancipated status is consistent with the statutory principle that parents are responsible for the support of their dependent children until the children attain the age of 21”).
- ³⁰ *Bogin v. Goodrich*, 696 N.Y.S.2d 317 (3d. Dep’t 1999) (stating “children are deemed emancipated if they attain economic independence through employment, entry into military service or marriage and, further, may be deemed constructively emancipated if, without cause, they withdraw from parental supervision and control”). For a discussion of emancipation through economic independence, see generally *Alice C. v. Bernard G.C.*, 602 N.Y.S.2d 623 (2d Dep’t 1993); *Eason v. Eason*, 446 N.Y.S.2d 392, 393 (2d Dep’t 1982); *Thomas B. v. Lydia D.*, 886 N.Y.S.2d 22 (1st Dep’t 2009). For a discussion of emancipation through entry into military service, see generally *Zuckerman v. Zuckerman*, 546 N.Y.S.2d 666 (2d Dep’t 1989); see also *Crimmins v. Crimmins*, 745 N.Y.S.2d 686, 689 (Fam. Ct. Orange Cty. 2002) (stating “when a young person is in active service to our country that he or she is in a ‘state of emancipation’”). But see *Fausser v. Fausser*, 271 N.Y.S.2d 59, 61 (Fam. Ct. Nassau Cty. 1966) (holding that a minor may unemancipate him- or herself upon completion of military service by becoming dependent again on his or her parents). For a discussion of emancipation through marriage, see *Henry v. Boyd*, 473 N.Y.S.2d 892 (4th Dep’t 1984); *Cochran v. Cochran*, 196 N.Y. 86 (2d Dep’t 1909); *Bach v. Long Island Jewish Hosp.*, 267 N.Y.S.2d 289 (Sup. Ct. Nassau Cty. 1966). For a discussion of constructive emancipation by withdrawal from parental supervision and control, see generally *In re Roe v. Doe*, 29 N.Y.2d 188

- (1971); *Kershaw v. Kershaw*, 701 N.Y.S.2d 739 (3d Dep't 2000); *Matter of Ogborn v. Hiltz*, 701 N.Y.S.2d 759 (3d Dep't 2000); *Foster v. Diagle*, 809 N.Y.S.2d 228 (3d Dep't 2006); *Labanowski v. Labanowski*, 772 N.Y.S.2d 734 (3d Dep't 2004); see also Merrill Sobie, Supplemental Practice Commentaries to N.Y. Fam. Ct. Act § 413, *Emancipation of the Child* (McKinney 2016) (following text of statute) (“[T]he doctrine of [self-emancipation] is almost exclusively applied only when the child has attained the majority age of eighteen.”); see also N.Y.S. Unified Court Sys., *Child and/or Spousal Support Frequently Asked Questions* (“A child may also be considered ‘emancipated’ if he or she is between 17 and 21, leaves the parents’ home and refuses to obey the parents’ reasonable commands.”), https://www.nycourts.gov/courts/nyc/family/faqs_support.shtml.
- ³¹ Telephone interview with Michael Williams, Staff Attorney, The Door (June 12, 2017). See The Door’s website for more information, <http://www.door.org/>.
- ³² *Id.*
- ³³ *Id.*
- ³⁴ N.Y. Correct. Law § 140(2) (McKinney 2017). Routine mental health treatment is defined to exclude psychiatric administration of medication unless it is part of an ongoing mental health plan or unless it is otherwise authorized by law. *Id.* For more information on what mental health services the law authorizes a minor to consent to, see *infra* Section IV (Mental Health Counseling and Services).
- ³⁵ N.Y. Pub. Health Law § 2505-a (McKinney 2017).
- ³⁶ N.Y. Penal Law § 70.20(1)(b) (McKinney 2017); N.Y. Correct. Law § 140(1) (McKinney 2017).
- ³⁷ N.Y. Penal Law § 70.20(1)(c) (McKinney 2017); N.Y. Correct. Law § 140(1) (McKinney 2017).
- ³⁸ N.Y. Penal Law § 70.20(1)(d) (McKinney 2017); N.Y. Correct. Law § 140(3) (McKinney 2017).
- ³⁹ N.Y. Correct. Law § 140(4) (McKinney 2017); N.Y. Penal Law § 70.20(1)(e) (McKinney 2017).
- ⁴⁰ N.Y. Fam. Ct. Act § 355.4 (McKinney 2017).
- ⁴¹ Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 *Pediatrics* 786, 790-91 (2013) (Table 1: listing states with statutory or judicial mature minor doctrines), <http://pediatrics.aappublications.org/content/131/4/786>.
- ⁴² *In re Application of Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (Sup. Ct. Queens Cty. 1990) (discussing “mature minor” doctrine in the context of finding that a nearly 18-year-old cancer patient lacked the maturity to decline lifesaving blood transfusions and recommending “that the legislature or the appellate courts take a hard look at the ‘mature minor’ doctrine and make it either statutory or decisional law in New York State”).
- ⁴³ See, e.g., Am. Med. Ass’n Council on Ethical and Judicial Affairs, Amendment to E-5.055 (Resolution 1-A-12), “Confidential Care for Minors,” (2013) (stating that “confidential care for adolescents is critical to improving patient health and that, while parental involvement in children’s health should generally be encouraged, parental consent should not act as a barrier to needed medical care” and “physicians should always permit competent

minors to consent to medical care, only notifying parents with the patient's consent"), <https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/ceja-3a13.pdf>; see also Am. Med. Ass'n, *Code of Medical Ethics' Opinion on Adolescent Care, Opinion 5.055 – Confidential Care for Minors*, Journal of Ethics, Vol. 16, No. 11: 901-902 (Nov. 2014) (enacting an amendment to E-5.055, stating, "physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities"), <http://journalofethics.ama-assn.org/2014/11/coet1-1411.html>; Am. Acad. of Pediatrics, *Informed Consent in Decision-Making in Pediatric Practice*, Pediatrics, Vol. 138, No. 2 (Aug. 2016) (stating "the mature-minor doctrine recognizes that there is a subset of adolescents who have adequate maturity and intelligence to understand and appreciate an intervention's benefits, risks, likelihood of success, and alternatives and can reason and choose voluntarily. Most states have mature-minor statutes in which the minor's age, overall maturity, cognitive abilities, and social situation as well as the gravity of the medical situation are considered in a judicial determination, finding that an otherwise legally incompetent minor is sufficiently mature to make a legally binding decision and provide his or her own consent for medical care."), <http://pediatrics.aappublications.org/content/early/2016/07/21/peds.2016-1485>.

⁴⁴ State law guarantees the confidentiality of health information. 8 N.Y.C.R.R. § 29.1(b)(8) (2017) (revealing personal information obtained in a professional capacity without the prior consent of the patient constitutes unprofessional conduct). Psychologists, social workers, and other mental health counselors are among those professionals "licensed, certified or registered pursuant to title

VIII of the Education Law," and therefore bound by confidentiality rules. 8 N.Y.C.R.R. § 29.1(b)(8) (2017); *id.* §§ 29.12, 29.15, 29.16. 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) (2017). And New York law establishes testimonial privileges shielding confidential patient or client information or communications to medical providers, psychologists, social workers, and rape crisis counselors. N.Y. C.P.L.R. 4504 (McKinney 2017) ("Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing, licensed practical nursing, dentistry, podiatry or chiropractic shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity."), 4507 ("The confidential relations and communications between a psychologist registered under the provisions of article one hundred fifty-three of the education law and his client are placed on the same basis as those provided by law between attorney and client, and nothing in such article shall be construed to require any such privileged communications to be disclosed."), 4508 ("A person licensed as a licensed master social worker or a licensed clinical social worker under the provisions of article one hundred fifty-four of the education law shall not be required to disclose a communication made by a client, or his or her advice given thereon, in the course of his or her professional employment"), 4510 ("A rape crisis counselor shall not be required to disclose a communication made by his or her client to him or her, or advice given thereon, in the course of his or her services. . . .").

In addition, federal and state law require the consent of a patient or other qualified person before health information may be shared. 45 C.F.R. § 164.508 (2017) (requiring patient

authorization for disclosure of health information); 10 N.Y.C.R.R. 300.5(a) (2017) (requiring authorization from the patient or another qualified person for sharing of electronic health records among health care entities); N.Y. Statewide Collaboration Process, *Privacy and Security Policies and Procedures for Qualified Entities and Their Participants in New York State under 10 N.Y.C.R.R. § 300.3(b)(1) § 1.1* (Version 3.4, June 2017) (requiring affirmative patient consent for sharing of electronic health information among health care entities), https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf.

⁴⁵ Regulations issued under the federal Health Insurance Portability and Accountability Act (HIPAA) provide that the minor is the “individual,” vested with authority to consent or deny consent to the disclosure of health information, when “[t]he minor consents to such health care service; no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person [the parent or guardian] be treated as the personal representative [who stands in for the minor].” 45 C.F.R. § 164.502(g)(3)(i)(A) (2017).

⁴⁶ 45 C.F.R. 164.502(g)(3)(i)(C) (2017).

⁴⁷ 10 N.Y.C.R.R. 300.1(h) (2017); see also 10 N.Y.C.R.R. § 300.5(b)(4) (2017).

⁴⁸ 10 N.Y.C.R.R. 300.5(b)(3)(ii) (2017). While protecting “minor consent patient information” from disclosure to parents, the New York regulations give those same parents the right to authorize the disclosure of such information to entities that participate in the Statewide Health Information Network, unless the minor is emancipated or “federal law or regulation requires the minor’s authorization.” 10

N.Y.C.R.R. 300.5(b)(3)(i) (2017). For further discussion of this regulation, see *infra* notes 97–100 and accompanying text.

⁴⁹ The federal HIPAA regulations, in turn, provide that when state or other law explicitly grants or denies parents access to a minor’s health information, that law controls regardless of who consented to the treatment at issue. 45 C.F.R. § 164.502(g)(3)(ii)(A), (B) (2017). Because health care providers who participate in the Statewide Health Information Network for New York are expressly forbidden to share health information about minor patients with their parents when the minor consented to the service that is the subject of the information, a breach of the state rule would also violate the federal rule.

⁵⁰ 45 C.F.R. §§ 160.400 to 160.506 (2017).

⁵¹ N.Y. Statewide Collaboration Process, *Oversight & Enforcement Policies and Procedures for QEs § 2.1.1* (Version 1.2.1 March 2016), https://www.health.ny.gov/technology/regulations/shin-ny/docs/oversight_and_enforcement_policies.pdf.

⁵² Any unprofessional conduct, see 8 N.Y.C.R.R. § 29.1 (2017), is professional misconduct, N.Y. Educ. Law §§ 6509(9) (McKinney 2017). Professional misconduct is punishable by reprimands, suspension or revocation of a license, fines, and other penalties. *Id.* § 6511.

⁵³ See, e.g., *Burton v. Matteliano*, 916 N.Y.S.2d 438, 440-41 (App. Div. 4th Dep’t 2011); *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 802 (App. Div. 4th Dep’t 1982).

⁵⁴ N.Y. Pub. Health Law § 18(2)(c) (McKinney 2017). Federal law reinforces that state law prohibitions on disclosure of health information

govern. 45 C.F.R. 164.502(g)(3)(ii)(B) (2017) (“If, and to the extent, prohibited by an applicable provision of State or other law, including applicable case law, a covered entity may not disclose, or provide access . . . to, protected health information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*.”). Moreover, even if a parent consented to the care, federal regulations permit (but do not require) a health care provider to deny a parent access to information if the provider determines in the exercise of professional judgment that such access is “reasonably likely to cause substantial harm to the individual [minor] or another person.” 45 C.F.R. 164.524(a)(3)(iii) (2017).

⁵⁵ N.Y. Pub. Health Law § 18(3)(c) (McKinney 2017).

⁵⁶ 45 C.F.R. 164.502(g)(5) (2017).

⁵⁷ 45 C.F.R. 164.502(g)(3)(i)(C) (2017).

⁵⁸ 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 (App. Div. 3d Dep’t 1989); *People v. Mirque*, 758 N.Y.S.2d 471, 474 (Crim. Ct. Bronx Cty. 2003). 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 *infra* notes 145–146 and accompanying text.

⁵⁹ Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. §§ 1232g(a)(1)(A), (B) (2017) (requiring schools that receive federal funding to give parents the right to “inspect and review the education records of their children”); N.Y. Educ. Law § 2-d(3)(b)(2) (McKinney 2017) (“Parents have the right to inspect and review the complete contents of their child’s education record.”).

⁶⁰ FERPA, 20 U.S.C. § 1232g(a)(4)(A) (2017).

⁶¹ *Owasso Indep. Sch. Dist. v. Falvo*, 534 U.S. 426, 433 (2002).

⁶² See, e.g., N.Y. Educ. Law §§ 901, 903-905 (McKinney 2017) (requiring health and dental screenings and certificates as a condition of enrollment and maintenance of the related records in school files); 8 N.Y.C.R.R. § 136.3(a)(2) (2017) (“It shall be the duty of the trustees and boards of education: . . . except where otherwise prohibited by law, to advise, in writing, the parent of, or other persons in parental relation to, each student in whom any aspect of the total school health program indicates such student has defective sight or hearing, or a physical disability or other condition which may require professional attention with regard to health. . . .”). Despite the broad language of this regulatory requirement, courts have read it to apply only to the records of mandatory health screenings. *Port Washington Teachers’ Ass’n v. Bd. of Educ.*, 478 F.3d 494, 501 n.3 (2d Cir. 2007) (noting that New York courts have limited the reach of the regulation to requiring notice to parents of the results of tests for sight, hearing, and sickle cell anemia, which are mandated by the authorizing legislation, N.Y. Educ. Law § 904) (citing *Bello v. Bd. of Educ.*, 527 N.Y.S.2d 924 (4th Dep’t 1988)).

⁶³ See *Owasso*, 534 U.S. at 433–34. While FERPA exempts from disclosure records that remain “in the sole possession of the maker thereof and which are not accessible or revealed to any other person except a substitute,” 20 U.S.C. § 1232g(a)(4)(B)(i) (2017), this exemption may have limited utility. Health records are often shared beyond the professional who makes them. Moreover, another provision explicitly exempts from disclosure to parents the health treatment records of students who are over 18 or in postsecondary educational institutions. 20 U.S.C. § 1232g(a)(4)(B)(iv) (2017). This provision implies that the

health records of minors under 18 or not yet in postsecondary education are generally accessible to parents.

- ⁶⁴ 42 U.S.C. 290dd-2 (2017). Note, however, that this law predates FERPA, and no court had decided which statute governs in the case of a conflict over whether a disclosure to parents is mandated or prohibited.
- ⁶⁵ 42 U.S.C. 290dd-2(b) (2017).
- ⁶⁶ The concept of personal liberty grounded in the Due Process Clause of the 14th 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, 598-60 & nn. 23-26 (1977) (citing *Roe v. Wade*, 410 U.S. 113, 152-153 (1973)). See, e.g., *Sterling v. Minersville*, 232 F.3d 190, 194-96 (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) (quoting *Doe v. Southeastern Pa. Transp. Auth.*, 72 F.3d 1133, 1141 (3d Cir.1995)); *Gruenke v. Seip*, 225 F.3d 290, 302-03 (3d Cir. 2000) (holding that a public school gym teacher who compelled a student to take a pregnancy test and failed to keep the test confidential violated the student's 14th Amendment privacy rights). In addition, the various professions maintain ethical standards that may counsel against disclosure. See, e.g., Nat'l Ass'n of Soc. Workers, *NASW Standards for the Practice of Social Work with Adolescents* 15-16 (Standard 8 - Confidentiality: "Social workers shall maintain adequate safeguards for privacy and confidentiality in their relationships with youths."), http://www.socialworkers.org/LinkClick.aspx?fileticket=Ut4ybE_GW4%3d&portalid=0; Nat'l Educ. Ass'n, *Code of Ethics* (Principle I - Commitment to the Student: "[T]he educator . . . [s]hall not disclose information about students obtained in the course of professional service unless disclosure serves a compelling professional purpose or is required by law."), <http://www.nea.org/home/30442.htm>.
- ⁶⁷ 8 N.Y.C.R.R. § 29.1(b)(8) (2017); N.Y. Educ. Law §§ 6509-6511 (McKinney 2017); *Burton*, 916 N.Y.S.2d at 440-41; *MacDonald*, 446 N.Y.S.2d at 802.
- ⁶⁸ FERPA, 20 U.S.C. § 1232g(b)(2)(A) (2017).
- ⁶⁹ See *Port Washington Teachers' Ass'n v. Bd. of Educ.*, 478 F.3d 494, 502 (2d Cir. 2007) (dismissing for lack of standing challenge by social worker and teachers' unions to what the court characterized as a nonmandatory district policy advising school social workers to report student pregnancies to parents; characterizing as "dicta" the trial court's decision upholding the policy).
- ⁷⁰ 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 2017); vital statistics, N.Y. Pub. Health Law, Article 41 (McKinney 2017); bites by rabid animals, 10 N.Y.C.R.R. § 2.14 (2017); congenital malformations, N.Y. Pub. Health Law § 2733 (McKinney 2017); lead poisoning, N.Y. Pub. Health Law § 1370-a(c) (McKinney 2017); pesticide poisoning, 10 N.Y.C.R.R. §§ 22.11-12 (2017); radiation illness and injury, 10 N.Y.C.R.R. § 16.9(c) (2017); and inflamed eyes within two weeks of birth, N.Y. Pub. Health Law § 2502 (McKinney 2017).
- ⁷¹ See, e.g., Am. Coll. of Obstetricians & Gynecologists, *Comm. on Adolescent Health Care*, *Comm. Op. No. 599, Adolescent Confidentiality and Electronic Health Records* (May 2014,

reaffirmed 2016) (recommending that health care providers inform parents and adolescents that the information each shares will be treated confidentially and advise them of any restrictions on the confidential nature of the relationship), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescent-Confidentiality-and-Electronic-Health-Records>; *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 J. Adolescent Health 160, 164 (2004) (advising professionals to discuss with minor patients circumstances that might result in breaches of confidentiality), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Aug-04-Confidential_Health_Care_for_Adolescents.pdf.

⁷² The following professionals who work with young people are mandated 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 2017). Therefore, if any of these professionals, in the course of their official duties, learn of information

that creates a reasonable suspicion that a child is being harmed by a caregiver, the professional must report this suspicion to the State Central Register.

⁷³ 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 2017); N.Y. Fam. Ct. Act § 1012(g) (McKinney 2017).

⁷⁴ N.Y. Soc. Serv. Law § 413(1)(a) (McKinney 2017).

⁷⁵ N.Y. Soc. Serv. Law § 413(1)(b) (McKinney 2017).

⁷⁶ N.Y. Soc. Serv. Law § 412(1) (McKinney 2017); N.Y. Fam. Ct. Act § 1012(e) (McKinney 2017). Under these laws, a caregiver commits abuse if the caregiver (1) inflicts or allows the infliction of a nonaccidental, physical injury that causes substantial risk of serious physical or emotional harm; or (2) creates or allows the creation of substantial risk of nonaccidental 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.

⁷⁷ A parent, guardian, custodian, or other person responsible for a minor's care engages in child neglect by failing to exercise a minimum degree of care, thereby causing, allowing, or creating a substantial risk of physical or emotional harm to the child, or by abandoning a child. N.Y. Soc. Serv. Law § 412(2) (McKinney 2017); N.Y. Fam. Ct. Act § 1012(f) (McKinney 2017).

⁷⁸ The term "allows" in the context of child neglect is intended to address the parent or legal caregiver who knew or "should have known about the abuse and failed to exercise a minimum degree of care to prevent or stop it." *Nicholson v. Scoppetta*, 787 N.Y.S.2d 196, 203 (Ct.

App. 2004) (holding that a battered mother may be found to have neglected her children “not because she is a victim of domestic violence or because her children witnessed the abuse, but rather because a preponderance of the evidence establishes that the children were actually or imminently harmed by reason of her failure to exercise even minimal care in providing them with proper oversight”); *id.* at 302 (“Courts must evaluate parental behavior objectively: would a reasonable and prudent parent have so acted, or failed to act, under the circumstances then and there existing.”) (citations omitted); see also *In re Christina P.*, 713 N.Y.S.2d 743 (2d Dep’t 2000) (finding a mother had neglected her daughter by failing to protect her from sexual abuse by the mother’s paramour, about which the mother knew or should have known); *In re Katherine C.*, 471 N.Y.S.2d 216, 219 (Fam. Ct. Richmond Cty. 1984) (same).

⁷⁹ N.Y. Soc. Serv. Law § 420 (McKinney 2017) (providing criminal and civil penalties for a mandated reporter who willfully fails to report). A mandated reporter who has reason to suspect child abuse, but who 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 that a teacher, as a mandated reporter, “is obligated to report suspected cases of child sexual abuse based upon facts and circumstances within the knowledge of the reporter at the time the abuse is suspected and may be held liable for a breach of that duty even though it might ultimately be determined that the abuse was not committed or allowed to have been committed by a ‘person legally responsible’ for the child”).

⁸⁰ N.Y. Soc. Serv. Law § 419 (McKinney 2017) (immunizing mandated reporters

from liability for making reports if they acted in good faith; presuming good faith of those who act within the scope of their employment and without misconduct or gross negligence). See, e.g., *Rine v. Chase*, 765 N.Y.S.2d 648 (App. Div. 2d Dep’t 2003) (affirming dismissal of a complaint against a social worker who made child abuse reports, later found to be unsubstantiated, based on statements children made in therapy); *Kempster v. Child Protective Servs.*, 515 N.Y.S.2d 807 (App. Div. 2d Dep’t 1987) (dismissing a complaint against a hospital for making a child abuse report, later found to be unsubstantiated, based on suspicious injuries to a 14-month-old baby). Courts have recognized that the grant of immunity is intended to “encourage the reporting of child abuse situations, and thereby afford children greater protection.” *Brown v. City of N.Y.*, 870 N.Y.S.2d 217, 223 (Sup. Ct. N.Y. Cty. 2008). This purpose would appear to be frustrated by a provision of the penal law that makes it a misdemeanor to “[r]eport, by word or action, an alleged occurrence or condition of child abuse or maltreatment . . . which did not in fact occur or exist” to either the statewide central register or to any mandated reporter. N.Y. Penal Law § 240.50(4) (McKinney 2017). No court has resolved this tension, but due process would pose a serious obstacle to the prosecution of an observer for making a good-faith report of child abuse just because it later turns out to be unfounded.

⁸¹ 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 2017). 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 2017). 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 2017). Any person who, in good faith, either makes or transmits such a report is immunized from civil liability, N.Y. Educ. Law §§ 1126(3), 1128(4) (McKinney 2017), 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 2017).

⁸² N.Y. Fam. Ct. Act § 1012(e)(iii) (McKinney 2017) (defining "abused child" to include minors whose parent or other legally responsible person "commits, or allows to be committed an offense against such child defined in article one hundred thirty of the penal law [delineating sex offenses].").

⁸³ N.Y. Penal Law § 130.20(1)-(2) (McKinney 2017) (defining sexual misconduct as engaging in sexual intercourse (meaning vaginal sex) or oral or anal sex with another person "without such person's consent"); N.Y. Penal Law § 130.05(2)(b) (McKinney 2017) ("Lack of consent results from . . . [i]ncapacity to consent."); N.Y. Penal Law § 130.05(3)(a) (McKinney 2017) ("A person is deemed incapable of consent when he or she is . . . less than 17 years old."). Other "statutory rape" sex crimes, which are 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 2017); second-degree rape occurs when the minor is younger than 15 and the partner is 18 or older, except that it is an affirmative defense if the defendant is less than four years older than the alleged victim, N.Y. Penal Law § 130.30 (McKinney 2017); and first-degree rape occurs when the minor is younger than 13 and the partner is 18 or older, or when the minor is younger than 11 and the partner is any age, N.Y. Penal Law § 130.35(3), (4) (McKinney 2017). 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 2017). 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 2017); 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 2017); 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 2017). 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 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).

⁸⁴ 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. In addition, it fails to recognize that the nature of parental supervision is frequently determined by the age of the parent, by culture, by religion, and by the child's gender. 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 Comm'r Soc. Servs. ex rel. Leslie C.*, 614 N.Y.S.2d 855, 861 (Fam. Ct. Kings Cty. 1994) (dismissing charges of abuse and neglect against the mother of a sexually active teenage 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 family court had 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").

Data from the 2011-2013 National Survey of Family Growth show that nationally, just over 40 percent of minors have sex before their 17th birthday. Gladys M. Martinez & Joyce C. Abma, *Sexual Activity, Contraceptive Use, and Childbearing of Teenagers Aged 15-19 in the United States*, Figure 2 (National Center for Health Statistics Data Brief no. 209, July 2015), <https://www.cdc.gov/nchs/products/databriefs/db209.htm>. Thus, a reading of the statutes that did not take into account the public policies outlined by the *Leslie C.* court would suggest that the parents of more than 406,000 New York State minors be reported on suspicion of child abuse or neglect, representing 40 percent of the total 1,016,517 teenagers aged 13, 14, 15, and 16 in New York State as of the 2010 census. U.S. Census Bureau, American

Factfinder, Single Years of Age and Sex: 2010 (NY), https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP2&prodType=table.

⁸⁵ *Leslie C.*, 614 N.Y.S.2d 855.

⁸⁶ N.Y. Mental Hyg. Law § 33.13 (McKinney 2017) protects the clinical records of patients and clients treated at a "facility." The law defines a facility to include "any place in which services for the mentally disabled are provided," N.Y. Mental Hyg. Law § 1.03(6) (McKinney 2017), and "any provider of services for individuals with mental illness or developmental disabilities which is operated by, under contract with, receives funding from, or is otherwise approved to render services by, a director of community services pursuant to article forty-one of this chapter or one or both of the offices [i.e., the office of mental health or the office for people with developmental disabilities], including any such provider which is exempt from the requirement for an operating certificate under article sixteen or article thirty-one of this chapter," N.Y. Mental Hyg. Law § 33.13(a) (McKinney 2017). The clinical records of patients treated in such facilities or by such providers are shielded from disclosure, except in certain circumstances, such as when disclosure is made "to an endangered individual and a law enforcement agency when a treating psychiatrist or psychologist has determined that a patient or client presents a serious and imminent danger to that individual." N.Y. Mental Hyg. Law § 33.13(c)(6), (c)(9) (v) (McKinney 2017); see also N.Y. C.P.L.R. § 4510(b)(2) (McKinney 2017) (rape crisis counselors "shall not be required to treat as confidential a communication by a client which reveals the intent to commit a crime or harmful act"); N.Y. C.P.L.R. § 4508(a)(2) (McKinney 2017) (same as to social workers).

- ⁸⁷ N.Y. Mental Hyg. Law § 33.13(c)(6) (McKinney 2017) (“Nothing in this paragraph shall be construed to impose an obligation upon a treating psychiatrist or psychologist to release information pursuant to this paragraph.”), (c)(9)(v) (same). Under the relevant New York case law, psychiatrists and psychologists are permitted to notify endangered individuals and will not be liable if they prove that their concern for the endangered person was reasonable, but no court has imposed on psychiatrists and psychologists an affirmative duty to report to the police or to endangered persons when a patient poses a threat of harm. *Juric v. Bergstraesser*, 963 N.Y.S.2d 755, 757-58 (App. Div. 3d Dep’t 2013) (recognizing that a physician may prevail in an affirmative defense to a patient’s suit for breach of confidentiality if the physician “has a reasonable basis to believe that plaintiff posed an actual, current, imminent threat” to another, but holding evidence in this case insufficient as a matter of law to establish such an affirmative defense); *Burton v. Matteliano*, 916 N.Y.S.2d 438, 440-41 (App. Div. 4th Dep’t 2011) (reversing dismissal of complaint against a physician for breach of confidentiality, but noting that the physician could assert affirmative defense based on “competing interests [that] support the need to disclose”) (citation omitted); *Kolt v. U.S.*, 1996 WL 607098 (W.D. N.Y. Oct. 2, 1996) (granting summary judgment to a Veterans Administration hospital in a suit by the estate of a wife who was killed by her husband, a psychiatric patient of the hospital, and noting the absence of evidence that a psychiatrist knew that the patient posed a serious and imminent danger of harm to his wife); *Oringer v. Rotkin*, 556 N.Y.S.2d 67, 68 (App. Div. 1st Dep’t 1990) (affirming summary judgment for a psychologist whose unrefuted 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”); *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 805 (App. Div. 4th Dep’t 1982) (stating in dicta 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,” but affirming the denial of a motion to dismiss a complaint that alleged breach of confidentiality because a physician had not asserted and proven affirmative defense that disclosure was necessary to prevent harm).
- ⁸⁸ N.Y. C.P.L.R. § 4504(a) (McKinney 2017).
- ⁸⁹ N.Y. C.P.L.R. § 4507 (McKinney 2017) (placing this privilege on the same basis as that between an attorney and a client).
- ⁹⁰ N.Y. C.P.L.R. § 4508(a) (McKinney 2017).
- ⁹¹ N.Y. C.P.L.R. § 4510(b) (McKinney 2017). A “rape crisis counselor” is a person who has 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 2017)) and who is working in an approved rape crisis program. N.Y. C.P.L.R. § 4510(a)(2) (McKinney 2017).
- ⁹² N.Y. C.P.L.R. § 4504(a) (McKinney 2017).
- ⁹³ N.Y. Fam. Ct. Act § 1046(a)(vii) (McKinney 2017). For example, a psychologist may not claim privilege to avoid disclosing a communication from a teenager that suggests physical abuse by a caregiver.
- ⁹⁴ N.Y. C.P.L.R. § 4504(b) (McKinney 2017); N.Y. C.P.L.R. § 4508(a)(3) (McKinney 2017). This exception applies to physicians, registered professional nurses, licensed practical nurses, dentists, podiatrists, chiropractors, and social workers, but 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) (affirming conviction for drug possession and rejecting the defendant's argument that doctor-patient privilege prevented the admission of evidence a doctor shared with police after recovering condoms containing illicit drugs from the defendant's digestive tract), with *People v. Saaratu*, 541 N.Y.S. 2d 889 (Sup. Ct., Bronx Cty. 1989) (granting a motion to quash the testimony of two doctors who operated on the defendant and discovered balloons containing heroin in his stomach, and a pathologist who took custody of the balloons, on the ground that the testimony was 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 that preempt or supersede the state law. See 42 U.S.C. § 290dd-2(c) (2017).

- ⁹⁵ N.Y. Penal Law § 265.25 (McKinney 2017) (requiring reports of such wounds to be made to the police); 10 N.Y.C.R.R. § 405.9(c)(2)(v), (vi)(c) (2017) (requiring hospitals to turn evidence of such crimes over to the police if police request it within 30 days of its collection).
- ⁹⁶ 8 N.Y.C.R.R. § 29.1 (2017); N.Y. Educ. Law § 6509(9) (McKinney 2017).
- ⁹⁷ 10 N.Y.C.R.R. § 300.5(b)(2) (2017); see also N.Y. Statewide Collaboration Process, *Privacy and Security Policies and Procedures for Qualified Entities and Their Participants in New York*

State under 10 N.Y.C.R.R. § 300.3(b)(1) § 1.5.1 (Version 3.4, June 2017), https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf.

- ⁹⁸ 10 N.Y.C.R.R. § 300.5(b)(3) (2017); see also N.Y. Statewide Collaboration Process, *Privacy and Security Policies and Procedures for Qualified Entities and Their Participants in New York State under 10 N.Y.C.R.R. § 300.3(b)(1) §§ 1.5.2, 1.5.3* (Version 3.4, June 2017), https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf.
- ⁹⁹ 10 N.Y.C.R.R. § 300.5(b)(3)(i) (2017); see also N.Y. Statewide Collaboration Process, *Privacy and Security Policies and Procedures for Qualified Entities and Their Participants in New York State under 10 N.Y.C.R.R. § 300.3(b)(1) § 1.5.2* (Version 3.4, June 2017), https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf.
- ¹⁰⁰ HIPAA, 45 C.F.R. § 160.103(g)(3)(i) (2017).
- ¹⁰¹ N.Y. Statewide Collaboration Process, *Privacy and Security Policies and Procedures for Qualified Entities and Their Participants in New York State under 10 N.Y.C.R.R. § 300.3(b)(1) § 1.4.2* (Version 3.4, June 2017) ("QEs [i.e., qualified entities] and Participants *may, but shall not be required to*, subject Sensitive Health Information to certain additional requirements, including but not limited to providing patients the option to withhold certain pieces of Sensitive Health Information from access via the SHIN-NY [i.e., Statewide Health Information Network for New York] governed by a QE.") (emphasis added), https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf.

- ¹⁰² 10 N.Y.C.R.R. § 300.5(a) (2017) (“Qualified entity participants may, but shall not be required to, provide patients the option to withhold patient information, including minor consent patient information, from the SHIN-NY.”). For a definition of “minor consent patient information,” see 10 N.Y.C.R.R. 300.1(h) (2017); 10 N.Y.C.R.R. § 300.5(b)(4) (2017).
- ¹⁰³ Harriet B. Fox & Stephanie J. Limb, *State Policies Affecting the Assurance of Confidential Care for Adolescents*, National Alliance to Advance Adolescent Health, April 2008 (surveying nationwide practices of how, when, and to whom explanations of benefits (EOBs) are mailed when adolescents seek various kinds of health care, and finding that EOB mailings to minors’ homes regularly compromise the confidentiality of health services, including those to which the minor was legally entitled to give consent), <http://www.thenationalalliance.org/pdfs/FS5.%20State%20Policies%20Affecting%20the%20Assurance%20of%20Confidential%20Care.pdf>.
- ¹⁰⁴ N.Y. Ins. Law § 3216(a)(4)(C) (McKinney 2017).
- ¹⁰⁵ N.Y. Pub. Health Law § 4903(2)(a) (McKinney 2017).
- ¹⁰⁶ 45 C.F.R. §§ 164.522(b)(1)(i), (ii) (2017); 11 N.Y.C.R.R. §§ 244.2, 244.3 (2017).
- ¹⁰⁷ *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); *Eisenstadt v. Baird*, 405 U.S. 438, 443 (1972) (holding that a Massachusetts statute permitting married persons to obtain contraceptives to prevent pregnancy while prohibiting single persons from doing the same violated the Equal Protection Clause of the 14th Amendment).
- ¹⁰⁸ *Carey v. Population Servs. Int’l*, 431 U.S. 678, 693 (1977) (plurality opinion) (invalidating New York statute that prohibited distribution of contraceptives to minors and holding “the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults”).
- ¹⁰⁹ In *Carey*, 431 U.S. at 694-96, the Court flatly rejected the notion that the state could legitimately impede access to contraceptive services as a means of discouraging sexual activity. A minor’s right to contraceptive services is more qualified, however, in the context of distribution within public schools. See *Alfonso v. Fernandez*, 606 N.Y.S.2d 259, 264 (App. Div. 2d Dep’t 1993) (holding that a condom availability program in a public school must contain a parental opt-out provision and distinguishing other contexts: “The distribution of condoms in our public high schools, where attendance is compulsory, . . . is quite different from making them available at clinics, where attendance is wholly voluntary. . . .”); *Jackson v. Peekskill City Sch. Dist.*, 106 F. Supp. 3d 420 (S.D.N.Y. 2015) (denying a motion to dismiss a claim that a teacher violated parents’ right to raise their child as they saw fit by allegedly driving a student off-site to obtain birth control). These decisions, however, are limited to their contexts and cannot be read to abrogate minors’ well-established rights under New York State law and the Constitution to consent to contraceptive care in other contexts.
- ¹¹⁰ See 42 U.S.C. 1396d(a)(4)(C) (2017) (covering “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. § 440.250(c) (2017) (“Family planning services and supplies must be limited to beneficiaries of childbearing age,

including minors who can be considered sexually active and who desire the services and supplies.”); 42 C.F.R. §§ 431.300–431.307 (2017) (outlining confidentiality protections in Medicaid and other medical assistance programs).

- ¹¹¹ 42 U.S.C. § 300(a) (2017) (authorizing Title X grants to “public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)”); 42 C.F.R. § 59.5(a) (2017) (“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.)”); 42 C.F.R. § 59.11 (2017) (requiring confidentiality in Title X programs).
- ¹¹² *Wilder v. Bernstein*, 645 F. Supp. 1292, 1307 (S.D.N.Y. 1986) (citing a settlement stipulation requiring access to family planning information, services, and counseling in order to satisfy the Free Exercise Clause concerns of children placed in religious foster care agencies), *aff’d*, 848 F.2d 1338 (2d Cir. 1988); *Arneth v. Gross*, 699 F. Supp. 450, 452 (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).
- ¹¹³ *Carey*, 431 U.S. at 694–96.
- ¹¹⁴ 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, 1196–97 (2d Cir. 1983) (federal regulation); *Planned Parenthood Fed’n of Am. v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983) (federal regulation).
- ¹¹⁵ 42 C.F.R. § 50.203 (2017) (barring sterilization of anyone under 21 in federally assisted family planning projects); 18 N.Y.C.R.R. § 505.13(e)(1)(ii) (2017) (same under New York regulation).
- ¹¹⁶ 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) (2017). The applicable chapters on sterilization apply to “every sterilization performed within the city of New York.” N.Y.C. Code § 17-403 (2017).
- ¹¹⁷ See, e.g., *Relf v. Mathews*, 403 F. Supp. 1235, 1238 (D.D.C. 1975); *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974).
- ¹¹⁸ See James Trussell et al., *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy*, Office of Population Research, Princeton University (June 2017), <http://ec.princeton.edu/questions/ec-review.pdf>. In 2010, the FDA approved a type of EC that is effective when taken within 120 hours. See FDA Press Release, *FDA approves Ella tablets for prescription emergency contraception* (August 13, 2010), <https://wayback>.

archive-it.org/7993/20170112215700/
http://www.fda.gov/NewsEvents/
Newsroom/PressAnnouncements/2010/
ucm222428.htm.

- ¹¹⁹ Am. Coll. of Obstetricians & Gynecologists, Comm. on Health Care for Underserved Women, ACOG Comm. Op. No. 707, *Access to Emergency Contraception* (July 2017) (recommending that doctors “[w]rite advance prescriptions for emergency contraception . . . to increase awareness and reduce barriers to immediate access”), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Emergency-Contraception>.
- ¹²⁰ On April 5, 2013, a federal district court ordered the FDA to lift age and point-of-access restrictions on all levonorgestrel-based emergency contraception. *Tummino v. Hamburg*, 936 F. Supp 2d 162 (E.D.N.Y. 2013). The FDA then removed point-of-access age restrictions on emergency contraception for minors of childbearing age. See FDA Press Release, *FDA Approves Plan B One-Step Emergency Contraceptive for Use Without a Prescription for All Women of Child-Bearing Potential*, (June 20, 2013), <https://wayback.archive-it.org/7993/20170112033121/http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm358082.htm>. The government website for New York City erroneously suggests that minors must be 15 years old to buy emergency contraception at a drugstore. See NYC.gov, *Emergency Contraception for Teens*, <http://www1.nyc.gov/nyc-resources/service/1071/emergency-contraception-for-teens>. As noted above, the FDA has removed age restrictions for all levonorgestrel-based emergency contraception, and neither New York City nor New York State requires minors under the age of 15 to present a prescription at a pharmacy.
- ¹²¹ 18 N.Y.C.R.R. 505.3(b)(1)(i) (2017); N.Y.S. Dep’t of Health, Office of Health Insurance Programs, *New York State Medicaid Family Planning Services Frequently Asked Questions*, 11 (May 2015), https://www.emedny.org/ProviderManuals/NYS_Medicaid_Family_Planning_FAQs_May_2015.pdf.
- ¹²² See *supra* note 111.
- ¹²³ Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 63 *Morbidity and Mortality Weekly Report* 1-29 (April 25, 2014), <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>.
- ¹²⁴ N.Y. Pub Health Law § 2805-p (McKinney 2017).
- ¹²⁵ See *supra* Section IV (Birth Control).
- ¹²⁶ See *supra* Section IV (Birth Control).
- ¹²⁷ See Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications after Abortion*, 125 *Obstetrics & Gynecology* 175 (2015), http://journals.lww.com/greenjournal/Citation/2015/01000/Incidence_of_Emergency_Department_Visits_and.29.aspx.
- ¹²⁸ *Planned Parenthood v. Casey*, 505 U.S. 833, 899-900 (1992); *Hodgson v. Minnesota*, 497 U.S. 417, 461 (1990) (O’Connor, J., concurring, in a controlling opinion that states the narrowest ground for upholding a two-parent notice statute on the ground that its constitutional infirmities were cured by the judicial bypass); *Bellotti v. Baird*, 443 U.S. 622, 643-644 (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 obtain an abortion without parental consent, minors in New York may do so based on federal protections.

¹²⁹ N.Y. Pub. Health Law § 17 (McKinney 2017) (“[R]ecords concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant. . . .”). 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 and subject to civil action. N.Y. Gen. Bus. Law § 394-e (McKinney 2017).

¹³⁰ Based on a national survey of 5,109 women seeking abortions, 476 of whom were minors, 64 percent of minors involved their mothers in their abortion decision and 38 percent involved their fathers. Lauren Ralph et al., *The Role of Parents and Partners in Minors’ Decisions to Have an Abortion and Anticipated Coping After Abortion*, 54 J. of Adolescent Health 428 (2014), [http://www.jahonline.org/article/S1054-139X\(13\)00520-X/fulltext](http://www.jahonline.org/article/S1054-139X(13)00520-X/fulltext); see also Lee A. Hasselbacher et al., *Factors Influencing Parental Involvement Among Minors Seeking an Abortion: A Qualitative Study*, 104 Am. J. of Pub. Health 2207 (2014) (“Factors that influenced whether minors involved a parent were classified into 4 main categories: (1) relationships with parents that were close or supportive, (2) the sense that disclosure was inevitable, (3) the need for financial or logistical assistance, and (4) circumstances in which disclosure was forced upon the minor.”), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202942/>.

¹³¹ See Hasselbacher et al., *Factors Influencing Parental Involvement Among Minors Seeking an Abortion: A Qualitative Study*, supra, at 2209 (“Many minors were concerned that informing a parent about the abortion would damage their relationship. . . . Minors with a troubled parent-daughter relationship described concerns based on fear of emotional or physical repercussions and detached relationships.”).

¹³² N.Y. Pub. Health Law § 2305(2) (McKinney 2017) (“A licensed physician, or in a hospital, a staff physician, may diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually transmitted disease, or has been exposed to infection with a sexually transmitted disease.”). The comprehensive list of STIs covered by this provision includes human papilloma virus (HPV), a virus linked to both cervical cancer and genital warts. 10 N.Y.C.R.R. § 23.1 (2017). The HPV vaccine is approved for use in girls and women ages 11 to 26 and is available through the vaccines for children program.

¹³³ N.Y. Pub. Health Law § 17 (McKinney 2017) (“records concerning the treatment of an infant patient for venereal disease . . . shall not be released or in any manner be made available to the parent or guardian of such infant”); 10 N.Y.C.R.R. § 23.4 (2017) (“When a health care provider diagnoses, treats or prescribes for a minor, without the consent or knowledge of a parent or guardian as permitted by section 2305 of the Public Health Law, neither medical nor billing records shall be released or in any manner be made available to the parent or guardian of such minor without the minor patient’s permission.”); see also 45 C.F.R. § 164.502(g)(3)(i)(A), (ii)(B) (2017).

¹³⁴ 10 N.Y.C.R.R. §§ 2.1, 2.10, 2.32 (2017).

¹³⁵ Under 10 N.Y.C.R.R. § 2.10 (2017), physicians must report the full name, age, and address of every individual with a suspected or confirmed case of a communicable disease to the city, county, or district health officer within whose jurisdiction the individual resides, along with the name of the suspected or confirmed communicable disease, if known; persons in charge of state health or other specially licensed facilities must make similar reports within the jurisdiction where the institution or facility is located.

¹³⁶ 10 N.Y.C.R.R. § 2.32 (2017).

¹³⁷ Disclosure of confidential HIV-related information is permitted in certain limited circumstances, including, among others, 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; (6) correctional facilities and employees, under certain circumstances; and (7) authorized agencies in connection with foster care or child adoption. N.Y. Pub. Health Law § 2782 (McKinney 2017). 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 nonprofessional 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.

¹³⁸ N.Y. Pub. Health Law § 2305(2) (McKinney 2017) (authorizing physicians to diagnose, prescribe, and treat minors without parental involvement when the minor “is infected with a sexually transmitted disease, or has been exposed to infection with a sexually transmitted disease”); 10 N.Y.C.R.R. § 23.1 (2017) (including HIV in the list of sexually transmitted diseases).

¹³⁹ For information on PrEP, see <https://www.cdc.gov/hiv/risk/prep/index.html>.

¹⁴⁰ N.Y. Pub. Health Law § 2781 (McKinney 2017); 10 N.Y.C.R.R. § 63.3 (2017). Only in very limited circumstances may an HIV test be ordered without the individual’s consent. For example, a person convicted of or adjudicated delinquent for certain sex offenses may be required to submit to an HIV test so that the victim may be informed of her or his exposure, but the defendant may decline to be informed of the results of the test. N.Y. Pub. Health Law § 2785-a (McKinney 2017); N.Y. Crim. Proc. Law § 390.15 (McKinney 2017); N.Y. Family Court Act § 347.1 (McKinney 2017). In addition, a litigant may be required to submit to an HIV test when his or her HIV status is at issue in the litigation. N.Y. C.P.L.R. § 3121(a) (McKinney 2017).

¹⁴¹ N.Y. Pub. Health Law § 2780(5) (McKinney 2017) (“‘Capacity to consent’ means an individual’s ability, determined *without regard to the individual’s age*, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment,

- procedure or disclosure.”) (emphasis added).
- ¹⁴² N.Y. Pub. Health Law § 2781-a (McKinney 2017).
- ¹⁴³ Pursuant to N.Y. Pub. Health Law § 2500-f (McKinney 2017) and 10 N.Y.C.R.R. §§ 69-1.1 to 69-1.9 (2017), 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. In addition, the law allows anonymous HIV testing without consent when: an accidental needlestick or other event causes potential occupational exposure to HIV; the person who is the source of the potential exposure is unable to provide consent; no person authorized to consent on behalf of the source is immediately available; and the exposed person will benefit by knowing the source person’s HIV test results. N.Y. Pub. Health Law § 2781(6)(e) (McKinney 2017); 10 N.Y.C.R.R. 63.3(c)(7) (2017).
- ¹⁴⁴ Health care providers who are not authorized by the commissioner to provide HIV-related tests on an anonymous basis must refer a person who requests an anonymous test to a site that does provide anonymous testing. N.Y. Pub. Health Law § 2781(4) (McKinney 2017).
- ¹⁴⁵ N.Y. Pub. Health Law §§ 2780(7) (McKinney 2017) (defining “confidential HIV related information”), 2782 (prohibiting disclosure of confidential HIV-related information except in specified circumstances); 10 N.Y.C.R.R. § 63.6 (2017) (Department of Health regulation ensuring confidentiality); 18 N.Y.C.R.R. § 360-8.1 (2017) (Department of Social Services regulation ensuring confidentiality in the Medicaid program).
- ¹⁴⁶ Such providers are subject to fines up to \$5,000 for each occurrence, prosecution for a misdemeanor crime, and charges of professional misconduct. N.Y. Pub. Health Law § 2783 (McKinney 2017); 8 N.Y.C.R.R. § 29.1(b)(8) (2017).
- ¹⁴⁷ N.Y. Pub. Health Law § 2782(1)(a) (McKinney 2017); 10 N.Y.C.R.R. § 63.6(a)(1) (2017).
- ¹⁴⁸ N.Y. Pub. Health Law § 2782(4)(e) (McKinney 2017); 10 N.Y.C.R.R. § 63.6(g) (2017).
- ¹⁴⁹ N.Y. Pub. Health Law § 2782(4)(e) (McKinney 2017); 10 N.Y.C.R.R. § 63.6(g) (2017).
- ¹⁵⁰ N.Y. Pub. Health Law § 2782(4)(e) (McKinney 2017); 10 N.Y.C.R.R. § 63.6(g)(2)(ii), 63.7(b) (2017).
- ¹⁵¹ N.Y. Pub. Health Law § 2782(1)(h) (McKinney 2017) (requiring disclosure to foster care and adoption agencies); 10 N.Y.C.R.R. § 63.6(a)(8) (2017) (same).
- ¹⁵² N.Y. Soc. Serv. Law § 373-a (McKinney 2017) (requiring foster care and adoption agencies to disclose to prospective foster or adoptive parents the medical histories of the children released to their care); N.Y. Soc. Serv. Law § 372(8) (McKinney 2017) (requiring same disclosure to relatives and others who assume care of a child through placements other than foster care or adoption); see also 10 N.Y.C.R.R. § 63.6(h) (2017) (allowing redisclosure to foster parents and prospective adoptive parents).
- ¹⁵³ N.Y. Pub. Health Law § 2782(1)(p) (McKinney 2017); see also 10 N.Y.C.R.R. § 63.6(e) (2017).
- ¹⁵⁴ 10 N.Y.C.R.R. § 63.5(a) (2017).
- ¹⁵⁵ N.Y. Pub. Health Law § 2783 (McKinney 2017).

- ¹⁵⁶ N.Y. Pub. Health Law §§ 2782(1)(k), 2785 (McKinney 2017); 10 N.Y.C.R.R. § 63.6(a) (12) (2017).
- ¹⁵⁷ N.Y. Pub. Health Law § 2785 (McKinney 2017).
- ¹⁵⁸ N.Y. Pub. Health Law § 2130(1) (McKinney 2017); 10 N.Y.C.R.R. § 63.4(a)(1) (2017).
- ¹⁵⁹ N.Y. Pub. Health Law § 2130(1) (McKinney 2017); 10 N.Y.C.R.R. § 63.4(a)(4) (2017).
- ¹⁶⁰ N.Y. Pub. Health Law § 2130(3) (McKinney 2017) (defining “known” contacts to include those known independently to the physician or revealed to the physician by the infected person); 10 N.Y.C.R.R. § 63.4(b) (2017) (same).
- ¹⁶¹ N.Y. Pub. Health Law § 2130(3) (McKinney 2017); 10 N.Y.C.R.R. § 63.4(b) (2017).
- ¹⁶² In fact, New York law calls only for public health officials to seek the cooperation of infected individuals. 10 N.Y.C.R.R. § 63.8(a)(3) (2017).
- ¹⁶³ N.Y. Pub. Health Law § 2136(3) (McKinney 2017).
- ¹⁶⁴ 10 N.Y.C.R.R. § 63.8(i) (2017).
- ¹⁶⁵ 10 N.Y.C.R.R. § 63.8(a)(3) (2017).
- ¹⁶⁶ N.Y. Pub. Health Law § 2782(4)(b) (McKinney 2017); 10 N.Y.C.R.R. § 63.8(a) (3) (2017).
- ¹⁶⁷ 10 N.Y.C.R.R. § 63.8(a)(1) (2017); see also N.Y.S. Dep’t of Health, *Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral & Partner Notification*, <https://www.health.ny.gov/diseases/aids/providers/regulations/domesticviolence/guide.htm> (requiring domestic violence screening during post-test counseling of HIV-infected individuals).
- ¹⁶⁸ N.Y.S. Dep’t of Health, *Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral & Partner Notification*, <https://www.health.ny.gov/diseases/aids/providers/regulations/domesticviolence/guide.htm>. If notification is deferred because of the risk of domestic violence, public health staff follow up with the provider in 30-120 days to ascertain the current status and to reinforce the importance of reassessing domestic violence risk and partner notification issues in subsequent contacts with the infected individual to determine if partner notification can occur. *Id.*
- ¹⁶⁹ N.Y. Pub. Health Law § 2130(1) (McKinney 2017); 10 N.Y.C.R.R. § 63.4(a) (2017).
- ¹⁷⁰ N.Y. Pub. Health Law § 2782(4)(a) (McKinney 2017).
- ¹⁷¹ N.Y. Pub. Health Law § 2782(4)(a) (McKinney 2017); 10 N.Y.C.R.R. § 63.8(a) (1) (2017).
- ¹⁷² N.Y. Pub. Health Law § 2130(1), (3) (McKinney 2017) (requiring contact reporting upon a determination that the patient is HIV-infected, an AIDS diagnosis, diagnosis of an HIV-related illness, or periodic monitoring of HIV infection by laboratory tests); 10 N.Y.C.R.R. § 63.4(a)(1), (b) (2017) (same).
- ¹⁷³ N.Y. Pub. Health Law § 2783(3)(a) (McKinney 2017) (immunizing health care 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).
- ¹⁷⁴ N.Y. Pub. Health Law § 2504(3) (McKinney 2017).
- ¹⁷⁵ N.Y. Pub. Health Law § 2504(1)-(2) (McKinney 2017).
- ¹⁷⁶ See generally *supra* Section III.

- ¹⁷⁷ *Id.*
- ¹⁷⁸ N.Y. Pub. Health Law § 2805-i (McKinney 2017); 10 N.Y.C.R.R. § 405.9(c)(1) (2017). Additionally, New York Public Health Law requires every hospital providing emergency treatment to a survivor of sexual assault to provide prompt written and oral information about emergency contraception, and to provide emergency contraception when requested. N.Y. Pub Health Law § 2805-p (McKinney 2017). Notwithstanding these statutes and regulations, not all hospitals provide emergency contraception as part of the medical services associated with a sexual assault. A patient who wants emergency contraception should ask specifically for this service if it is not automatically offered. For information about HIV prophylaxis after a sexual assault, see <https://www.cdc.gov/hiv/basics/pep.html>.
- ¹⁷⁹ N.Y. Pub. Health Law § 2805-i(1)(b), (3) (McKinney 2017); 10 N.Y.C.R.R. § 405.9(c) (2017).
- ¹⁸⁰ 10 N.Y.C.R.R. § 405.9(c) (2017).
- ¹⁸¹ N.Y. Pub. Health Law § 2805-i (McKinney 2017); 10 N.Y.C.R.R. § 405.9(c)(2)(ii) (2017) (defining sexual assault evidence to include, “as appropriate to the injuries sustained in each case, slides, cotton swabs, clothing or portion thereof, hair combings, fingernail scrapings, photographs, and other items specified by the local police agency and forensic laboratory in each particular case”). Survivors should note that not all hospitals are equipped with “rape kits” and should therefore inquire as to their availability before going to the hospital, if possible.
- ¹⁸² Minors may consent to pregnancy testing and counseling, administration of emergency contraception, STI diagnosis and treatment, and HIV testing and treatment. See generally *supra* Section IV.
- ¹⁸³ N.Y. C.P.L.R. 4510(a)(3) (McKinney 2017) (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); *id.* 4510(c) (providing that only the rape crisis client may waive the privilege, permitting the counselor to disclose information, unless the client has been “adjudicated incompetent,” in which case a personal representative may waive the privilege).
- ¹⁸⁴ When a sexual assault victim is admitted to a hospital, the hospital must seek “patient consent, or consent of the person authorized to act on the patient’s behalf, for collection and storage of the sexual offense evidence.” 10 N.Y.C.R.R. § 405.9(c)(2)(vi) (2017). The New York State Department of Health “retains its longstanding position [that] [a] mature minor who presents at a hospital emergency department may consent or may choose not to consent, without parental involvement, to a forensic exam, in the course of post-sexual assault care.” Email from Lauren J. Tobias, Director, Division of Family Health, N.Y.S. Dep’t of Health, to Katharine Bodde, Policy Counsel, NYCLU (Oct. 24, 2017, 3:17 p.m. EDT) (on file with the NYCLU).
- The Public Health Law makes hospitals responsible for collecting and maintaining evidence of sexual offenses, N.Y. Pub. Health Law § 2805-i(1)(a), (2) (McKinney 2017), and entitles the “alleged sexual offense victim” to control whether the hospital releases “privileged evidence” to the police, *id.* § 2805-i(2). Privileged evidence is evidence collected or obtained from the patient during the hospital’s examination and treatment of injuries sustained as a result of a

sexual offense. 10 N.Y.C.R.R. § 405.9(c)(2)(iv) (2017). Nonprivileged evidence is evidence obtained from suspected child abuse victims or evidence derived from other crimes that must be reported (e.g., injuries arising from or caused by the discharge of a gun or firearm, burn injuries, or life-threatening wounds inflicted by a knife or other sharp instrument). *Id.* § 405.9(c)(2)(v) (2017). Hospitals must turn nonprivileged evidence over to the police on their request without regard to the consent of the alleged victim. N.Y. Pub. Health Law § 2805-i(2)(a) (McKinney 2017); 10 N.Y.C.R.R. § 405.9(c)(2)(vi)(c).

¹⁸⁵ Because the minor is entitled to consent independently to reproductive health services (e.g., STI testing and treatment, HIV testing and treatment, and emergency contraception, see *generally supra* Section IV), an inference may be drawn that would allow the minor also to consent to the treatment of injuries related to the assault; otherwise, the minor's right to confidential reproductive health care would be vitiated. Additionally, if related injuries require immediate medical attention, a health care provider can generally treat a minor without parental consent. N.Y. Pub. Health Law § 2504 (McKinney 2017).

¹⁸⁶ 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.

¹⁸⁷ N.Y. Soc. Serv. Law § 413 (McKinney 2017); 10 N.Y.C.R.R. § 405.9(d) (2017). Such reports must be made to the State Central Register of Child Abuse and Maltreatment, not to the police.

¹⁸⁸ N.Y. Penal Law § 265.25 (McKinney 2017) (requiring reports of such wounds to be made to the police); 10 N.Y.C.R.R. § 405.9(c)(2)(v), (vi)(c) (2017) (requiring hospitals to turn evidence of such crimes

over to the police if police request it within 30 days of its collection).

¹⁸⁹ N.Y. C.P.L.R. §§ 4504(b), 4508(a)(3) (McKinney 2017).

¹⁹⁰ See *infra* notes 201-215 and accompanying text.

¹⁹¹ See *supra* notes 134-137, 158-159 and accompanying text.

¹⁹² N.Y. Mental Hyg. Law § 33.21(a)(3) (McKinney 2017). For the purposes of independent consent by a minor, outpatient services are defined to *exclude* 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 2017). "Outpatient program[s] licensed or operated pursuant to the regulations of the commissioner of mental health" refer to programs licensed pursuant to the approval process outlined by 14 N.Y.C.R.R. § 551 (2017) and the certification process outlined by 14 N.Y.C.R.R. § 587.5 (2017). Such programs include: assertive community treatment (ACT) programs operated pursuant to 14 N.Y.C.R.R. § 508.3 (2017); clinics operated pursuant to 14 N.Y.C.R.R. §§ 587.8 and 587.9 (2017); comprehensive psychiatric emergency programs (CPEPs) operated pursuant to 14 N.Y.C.R.R. § 590 (2017); continuing day treatment programs operated pursuant to 14 N.Y.C.R.R. § 587.10 (2017); day treatment programs serving children operated pursuant to 14 N.Y.C.R.R. § 587.11 (2017); intensive psychiatric rehabilitation treatment programs operated pursuant to 14 N.Y.C.R.R. § 587.13 (2017); partial hospitalization programs operated pursuant to 14 N.Y.C.R.R. § 587.12 (2017); and personalized recovery oriented services (PROS) operated pursuant to 14 N.Y.C.R.R. § 512 (2017). For further reading on the services provided by these licensed outpatient programs, see <https://www.omh.ny.gov/omhweb/licensing/definitions.htm>.

- ¹⁹³ N.Y. Mental Hyg. Law § 33.21(c) (McKinney 2017). 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. *Id.*
- ¹⁹⁴ N.Y. Mental Hyg. Law § 33.21(e)(2) (McKinney 2017).
- ¹⁹⁵ N.Y. Mental Hyg. Law § 33.21(b) (McKinney 2017).
- ¹⁹⁶ N.Y. Mental Hyg. Law § 33.21(d) (McKinney 2017).
- ¹⁹⁷ Such documentation must include a written statement signed by the minor indicating that the minor is voluntarily seeking services. N.Y. Mental Hyg. Law § 33.21(c) (McKinney 2017).
- ¹⁹⁸ N.Y. Mental Hyg. Law § 9.13(a) (McKinney 2017). Parental consent is generally necessary for the nonemergency administration of psychotropic medications to minors in inpatient mental health facilities. N.Y. Mental Hyg. Law § 33.21(e)(1) (McKinney 2017). However, a 16- or 17-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, or (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 2017). In the second and third situations, confirmation by a second, independent psychiatrist is required. *Id.*
- ¹⁹⁹ N.Y. Mental Hyg. Law § 9.07(a) (McKinney 2017).
- ²⁰⁰ N.Y. Mental Hyg. Law § 9.09 (McKinney 2017).
- ²⁰¹ N.Y. Mental Hyg. Law § 9.13(b) (McKinney 2017) (allowing the involuntary commitment of an individual who is "mentally ill and in need of retention for involuntary care or treatment"); N.Y. Mental Hyg. Law § 9.01 (McKinney 2017) ("[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.").
- ²⁰² N.Y. Mental Hyg. Law § 9.13 (b) (McKinney 2017).
- ²⁰³ *See, e.g., Rodriguez*, 72 F.3d at 1061.
- ²⁰⁴ N.Y. Pub. Health Law § 2504(4) (McKinney 2017).
- ²⁰⁵ N.Y. Mental Hyg. Law § 33.13(c), (e), (f) (McKinney 2017) (protecting confidentiality of mental health records); *see also id.* § 33.14 (permitting patients to move to seal mental health records). When a minor acts on his or her own behalf to consent to mental health treatment, the minor will control the information related to that treatment. *Id.* § 33.16(b)

- (3) (granting parents and guardians access to their minor children's mental health records "concerning care and treatment for the infant for which the consent of a parent or guardian was obtained or has been requested") (emphasis added); see also generally, 45 C.F.R. § 164.502(g)(3)(i)(A) (2017) (giving minors the right to control information related to health services to which they have given independent, legal consent).
- ²⁰⁶ The confidentiality provisions apply to any facility "licensed or operated by the office of mental health or the office for people with developmental disabilities, hereinafter referred to as the offices." N.Y. Mental Hyg. Law § 33.13(a), (c) (McKinney 2017). But these provisions also apply to any facility "in which services for the mentally disabled are provided," including but not limited to "a psychiatric center, developmental center, institute, clinic, ward, institution, or building," N.Y. Mental Hyg. Law § 1.03(6) (McKinney 2017), and "any provider of services for individuals with mental illness or developmental disabilities which is operated by, under contract with, receives funding from, or is otherwise approved to render services by, a director of community services pursuant to article forty-one of this chapter or one or both of the offices, including any such provider which is exempt from the requirement for an operating certificate under article sixteen or article thirty-one of this chapter," N.Y. Mental Hyg. Law § 33.13(a), (e) (McKinney 2017).
- ²⁰⁷ N.Y. Mental Hyg. Law § 33.16(c)(2) (McKinney 2017).
- ²⁰⁸ N.Y. Mental Hyg. Law § 33.16(b)(3) (McKinney 2017).
- ²⁰⁹ See, e.g., Am. Psychiatric Ass'n, *Ethics Primer of the American Psychiatric Association*, 16-17 (2001); see also Am. Psychological Ass'n, *Ethical Principles of Psychologists and Code of Conduct*, Ethical Standards 4.01, 4.04, 4.05 (effective date Jan. 1, 2017), <http://www.apa.org/ethics/code/ethics-code-2017.pdf>.
- ²¹⁰ N.Y. Mental Hyg. Law § 33.13(c), (d) (McKinney 2017).
- ²¹¹ N.Y. Mental Hyg. Law §§ 33.23, 33.25 (McKinney 2017). This reporting rule applies to a wide range of facilities, including psychiatric centers, developmental centers, institutes, clinics, or wards that provide services for patients with mental disabilities. *Id.* § 1.03(6) (McKinney 2017).
- ²¹² See 14 N.Y.C.R.R. § 624.1 (2017) for a description of the covered facilities.
- ²¹³ See N.Y. Mental Hyg. Law §§ 16.13(b), 13.21(b) (McKinney 2017) (requiring investigation and reporting of reportable incidents to Vulnerable Persons' Central Register); 14 N.Y.C.R.R. §§ 624.3 (2017) (defining reportable incidents); 624.4 (defining notable occurrences); 624.5 (requiring reporting of reportable incidents and serious notable occurrences to oversight agencies and Vulnerable Persons' Central Register, among others); 624.6(f) (requiring notice of all reportable incidents and notable occurrences to parents). Parents are also allowed to request and receive records from such facilities. *Id.* § 624.8(b).
- ²¹⁴ N.Y. Mental Hyg. Law §§ 16.13(b), 13.21(b) (McKinney 2017).
- ²¹⁵ N.Y. Mental Hyg. Law §§ 7.21(b) (requiring reporting of reportable incidents to Vulnerable Persons' Central Register, which must in turn forward allegations of crimes to law enforcement), 31.11 (requiring reporting of crimes against patients, including unauthorized sexual contact, to law enforcement) (McKinney 2017); 14 N.Y.C.R.R. §§ 524.5 (defining reportable incidents), 524.8(a)(1) (requiring reports of reportable incidents to Vulnerable Persons' Central Register), 524.12 (requiring reports to next of kin

- and qualified persons, including parents of minor patients) (2017).
- ²¹⁶ N.Y. Mental Hyg. Law § 1.03 (McKinney 2017) (defining “chemical dependence” as “the repeated use of alcohol and/or one or more substances to the extent that there is evidence of physical or psychological reliance on alcohol and/or substances, the existence of physical withdrawal symptoms from alcohol and/or one or more substances, a pattern of compulsive use, and impairment of normal development or functioning due to such use in one or more of the major life areas including but not limited to the social, emotional, familial, educational, vocational, and physical. Unless otherwise provided, for the purposes of this chapter, the term ‘chemical dependence’ shall mean and include alcoholism and/or substance dependence.”).
- ²¹⁷ N.Y. Mental Hyg. Law § 22.11(b) (McKinney 2017).
- ²¹⁸ N.Y. Mental Hyg. Law § 22.11(c)(1) (McKinney 2017) (requiring that the admitting physician fully document in the minor’s medical record the reasons that parental involvement was not required for the treatment of such minor in the particular situation).
- ²¹⁹ N.Y. Mental Hyg. Law § 22.11(c)(2) (McKinney 2017) (requiring that the program director fully document in the minor’s medical record the reasons that parental involvement was not required for the treatment of such minor in the particular situation).
- ²²⁰ *Id.*
- ²²¹ N.Y. Mental Hyg. Law § 22.11(a) (McKinney 2017).
- ²²² N.Y. Mental Hyg. Law § 22.11(d)(1)(ii) (McKinney 2017).
- ²²³ N.Y. Mental Hyg. Law § 22.11(d)(1)(iv)(B) (McKinney 2017).
- ²²⁴ N.Y. Mental Hyg. Law § 22.11(d)(1)(iv)(C) (McKinney 2017).
- ²²⁵ 42 U.S.C. § 290dd-2(a) (2017) (“Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall . . . be confidential . . .”).
- ²²⁶ 42 U.S.C. § 290dd-2(b) (2017).
- ²²⁷ 42 C.F.R. § 2.14(a) (2017).
- ²²⁸ 42 C.F.R. § 2.14(b)(1).
- ²²⁹ 42 C.F.R. § 2.14(b)(2), (c).
- ²³⁰ 42 C.F.R. § 2.64 (2017) (detailing the procedure and the substantive showing necessary to attain a court-ordered disclosure).
- ²³¹ 42 U.S.C. § 290dd-2(c) (2017).
- ²³² *Comm’r Soc. Servs. v. David R.S.*, 451 N.Y.S.2d 1, 4 (Ct. App. 1982) (“Broad interpretation furthers the objectives of the Federal statute addressing drug and alcohol abuse prevention, treatment and rehabilitation by not chilling the willingness or discouraging the readiness of individuals to come to facilities operated under the statute.”).
- ²³³ 42 C.F.R. § 2.14(a) (2017) (allowing a minor patient who has the legal capacity to consent to treatment to direct disclosure of information); *id.* § 2.14(b) (prohibiting communication with parents about a minor’s application for substance abuse services, unless the minor consents or lacks the capacity

- for rational decision-making regarding such consent).
- ²³⁴ See generally N.Y. Mental Hyg. Law § 22.05(b) (McKinney 2017) (“All records of identity, diagnosis, prognosis, or treatment in connection with a person’s receipt of chemical dependence services shall be confidential and shall be released only in accordance with applicable provisions of the public health law, any other state law, federal law and duly executed court orders.”).
- ²³⁵ N.Y. Pub. Health Law § 2504(4) (McKinney 2017).
- ²³⁶ *Sullivan v. Montgomery*, 279 N.Y.S. 575, 577 (City Ct. 1935).
- ²³⁷ N.Y. Pub. Health Law § 18(2)(c) (McKinney 2017).
- ²³⁸ *Id.*
- ²³⁹ N.Y. Pub. Health Law § 18(3)(c) (McKinney 2017).
- ²⁴⁰ See *supra* Section IV (Mental Health Counseling and Services).
- ²⁴¹ See generally *supra* Section III.
- ²⁴² N.Y. Human Rights Rules, § 466.13(b)(1) (McKinney 2017) (Book 18 App.).
- ²⁴³ *Id.*, § 466.13(c).
- ²⁴⁴ *Id.*, § 466.13(b)(3), (d); see also *Doe v. Bell*, 754 N.Y.S.2d 846, 851, 853 (Sup. Ct. 2003) (holding that gender identity disorder is a disability under New York’s Human Rights Law such that a trans 17-year-old in foster care could not be forbidden to wear female clothing).
- ²⁴⁵ 18 N.Y.C.R.R. § 505.2(l)(2)(i) (2017) (A minor trans patient seeking hormone therapy must: (1) meet the criteria for a diagnosis of gender dysphoria; (2) have reached puberty, with a resulting increase in gender dysphoria; (3) have no complicating psychiatric condition; (4) have adequate psychological and social support during treatment; and (5) demonstrate understanding of the risks and benefits of hormone therapy and sex reassignment.).
- ²⁴⁶ *Id.* § 505.2(l)(2)(ii).
- ²⁴⁷ *Id.* § 505.2(l)(3)(i), (ii).
- ²⁴⁸ N.Y.C. Admin. for Children’s Servs., Policy and Procedure 2014/xx, *Non-Medicaid Reimbursable Treatments and Services for Children in the Custody of the Administration for Children’s Services* 4 & n. 3 (Dec. 16, 2014), https://www1.nyc.gov/assets/acs/pdf/lgbtq/14_12_16_NMR_signed_interim_policy.pdf. A supplemental policy further clarifies that trans-related care includes “supportive psychotherapy, hormonal therapies, surgical procedures, voice therapy, and electrolysis or laser hair removal that trans people seek in relation to their gender.” Memorandum from Benita Miller, N.Y.C. Admin. for Children’s Servs., to ACS and Provider Agency Staff, NMR [Non-Medicaid Reimbursable Treatment] Guidance for Trans-Related Healthcare 1 n.1 (Jan. 29, 2013), https://www1.nyc.gov/assets/acs/pdf/lgbtq/acs_NMR_Trans-Related_Healthcare.pdf.
- ²⁴⁹ N.Y.S. Office of Children and Family Servs., *A Medical Guide for Youth in Foster Care* 2-4 (Aug. 2011) (describing the general practice of asking parents to delegate the consent function to the foster care agency but noting circumstances in which minors may consent on their own), <http://ocfs.ny.gov/main/publications/Pub5116SINGLE.pdf>; N.Y.C. Admin. for Children’s Servs., Policy and Procedure 2014/08, *Medical Consents for Children in Foster Care* 4-6 (Sept. 16, 2014) (noting the general rule that parental or agency consent is required but outlining circumstances in which a minor can consent independently), http://www1.nyc.gov/assets/acs/pdf/policy_library_search/2014/E.pdf.

- ²⁵⁰ N.Y.C. Admin. for Children's Servs., Policy and Procedure 2014/08, *Medical Consents for Children in Foster Care 4* (Sept. 16, 2014), http://www1.nyc.gov/assets/acs/pdf/policy_library_search/2014/E.pdf.
- ²⁵¹ *Id.* at 6.
- ²⁵² The disclosable medical history includes information setting forth conditions or diseases believed to be hereditary, any drugs 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 2017); N.Y. Soc. Serv. Law § 372(8) (McKinney 2017) (requiring disclosure to relatives and others who assume care of a child through placements other than foster care or adoption).
- ²⁵³ N.Y. Pub. Health Law § 2782(1)(h) (McKinney 2017) ("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.").
- ²⁵⁴ N.Y. Soc. Serv. Law § 373-a (McKinney 2017); N.Y. Soc. Serv. Law § 372(8) (McKinney 2017).
- ²⁵⁵ N.Y. Pub. Health Law §§ 2781(2)(d), (4) (McKinney 2017).
- ²⁵⁶ 18 N.Y.C.R.R. § 441.22(a) (2017) (requiring foster care agencies to provide comprehensive medical and health services for every foster child in their care); 18 N.Y.C.R.R. § 507.1(a) (2017).
- ²⁵⁷ 18 N.Y.C.R.R. 463.1 (2017) ("Each local social services department shall offer and provide promptly upon request . . . social, education and medical family-planning services to persons of child-bearing age, including minors who can be considered sexually active, who are applicants for or recipients of public-assistance, recipients of medical assistance only, or recipients of supplemental security income."); 18 N.Y.C.R.R. § 507.1(c)(9) (2017) (requiring social services districts to provide or arrange for family planning services for foster children within 30 days of a request); 18 N.Y.C.R.R. § 463.2(b)(2) (2017) (same for child care agencies).
- ²⁵⁸ 18 N.Y.C.R.R. § 505.2(l)(2) (2017).
- ²⁵⁹ See *supra* note 248.
- ²⁶⁰ Memorandum from Benita Miller, N.Y.C. Admin. for Children's Servs., to ACS and Provider Agency Staff, NMR [Non-Medicaid Reimbursable Treatment] Guidance for Trans-Related Healthcare 1 (Jan. 29, 2013) ("[T]he foster care agency must comply with all existing medical consent requirements. . . ."), https://www1.nyc.gov/assets/acs/pdf/lgbtq/acs_NMR_Trans-Related_Healthcare.pdf. For the general consent requirements, see N.Y.S. Office of Children and Family Servs., *A Medical Guide for Youth in Foster Care 2-4* (Aug. 2011), <http://ocfs.ny.gov/main/publications/Pub5116SINGLE.pdf>; N.Y.C. Admin. for Children's Servs., Policy and Procedure 2014/08, *Medical Consents for Children in Foster Care 4-6*, http://www1.nyc.gov/assets/acs/pdf/policy_library_search/2014/E.pdf.
- ²⁶¹ For specific information on income and immigration eligibility requirements, as well as details concerning how a young person enrolls in one of these programs, please consult a teen advocacy organization, such as The Door, or call one of the phone numbers included in this section.

- ²⁶² Children's Aid Society, *Public Benefits for Minors and Emancipated Youth* (undated) (on file with the NYCLU).
- ²⁶³ *Id.*
- ²⁶⁴ *Id.*
- ²⁶⁵ *Id.*
- ²⁶⁶ *Id.*
- ²⁶⁷ *Id.*
- ²⁶⁸ This income level (\$35,524 per year for a family of two) constitutes 223% of the federal poverty level, which is the current eligibility threshold for pregnant women and infants under age one. N.Y.S. Dep't of Health, *Medicaid (Annual and Monthly) Income Levels for Pregnant Women and Children* (March 2015), https://www.health.ny.gov/community/pregnancy/health_care/prenatal/income.htm; N.Y. Soc. Servs. Law § 366(1)(a)(3) (McKinney 2017) (defining "family size" in the case of a pregnant woman to include "herself plus the number of children she is expected to deliver").
- ²⁶⁹ N.Y.S. Dep't of Health, *Medicaid Prenatal Care Standards* (Oct. 2016), https://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/; N.Y. Soc. Serv. Law § 366(1)(d)(3) (McKinney 2017) (providing that pregnant women are covered "during pregnancy and during the sixty-day period beginning on the last day of pregnancy").
- ²⁷⁰ N.Y. Soc. Serv. Law § 366-g (McKinney 2017); 18 N.Y.C.R.R. § 360-3.3(c)(6) (2017).
- ²⁷¹ N.Y.S. Dep't of Health, *Medicaid (Annual and Monthly) Income Levels for Pregnant Women and Children* (March 2015), https://www.health.ny.gov/community/pregnancy/health_care/prenatal/income.htm.
- ²⁷² 42 U.S.C. § 1396a(e)(4) (2017); 42 C.F.R. § 435.117 (2017); N.Y. Soc. Serv. Law § 366-g(4)(a) (McKinney 2017) ("A child under the age of one year whose mother is receiving medical assistance, or whose mother was receiving medical assistance on the date of the child's birth . . . 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.").
- ²⁷³ N.Y. Soc. Serv. Law § 365-a(6) (McKinney 2017) (providing coverage for pregnant women to the extent that federal financial participation is available, except that coverage will not lapse "solely by reason of the immigration status of the otherwise eligible pregnant woman"); N.Y.C. Human Res. Admin., Dep't of Soc. Servs., *Guide to Health Insurance and Health Care Services for Immigrants in New York City* 1 (2016) (table titled "Comprehensive Health Insurance Coverage" states, "All pregnant women, including undocumented women" are eligible for Medicaid coverage), <http://www1.nyc.gov/assets/ochia/downloads/pdf/guide-to-health-insurance-for-immigrants.pdf>; Kaiser Comm'n on Key Facts, *Medicaid and the Uninsured* (July 2009) (Table 2 lists New York among the states that offer state coverage for all documented and most undocumented immigrants for pregnancy-related care), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7933.pdf>.
- ²⁷⁴ N.Y. Soc. Serv. Law § 366-g (McKinney 2017); 18 N.Y.C.R.R. § 360-3.3(c)(6) (2017).
- ²⁷⁵ N.Y.S. State Dep't of Health, *Comprehensive Family Planning and Reproductive Health Care Services Program, Family Planning Extension Program*, https://www.health.ny.gov/community/pregnancy/family_plan-ning/; N.Y.C. Human Res. Admin., *Family Planning Extension Program*, <https://www1.nyc.gov/site/ochia/coverage-care/family-planning-extension-program.page>.

- ²⁷⁶ Federal law provides that a state Medicaid plan must “provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.” 42 U.S.C. § 1396a(a)(7) (2017); see also 42 C.F.R. § 431.305 (2017) (requiring state Medicaid agencies to safeguard information about “medical services provided,” among other things); 42 C.F.R. 431.306 (2017) (restricting state Medicaid agencies’ release of information and requiring consent of the “family or individual, whenever possible” before release to a third party). New York law implements these federal mandates. See N.Y. Soc. Serv. Law § 367-b(4) (McKinney 2017) (“Information relating to persons applying for or receiving medical assistance shall be considered confidential and shall not be disclosed to persons or agencies other than those considered entitled to such information in accordance with [N.Y. Soc. Serv. Law § 136 (McKinney 2017) (protecting public welfare records and specifying grounds for disclosure)] when such disclosure is necessary for the proper administration of public assistance programs.”).
- ²⁷⁷ 11 N.Y.C.R.R. §§ 244.2, 244.3 (2017) (requiring insurers under Medicaid, Child Health Plus, and other programs to develop confidentiality protocols to accommodate reasonable requests from covered individuals to contact them through alternative means or at alternative locations and forbidding insurers from disclosing information about a requestor’s location or health services to the policyholder).
- ²⁷⁸ N.Y.S. Dep’t of Health, *Opt-Out Process Frequently Asked Questions (FAQs): New York’s Delivery System Reform Incentive Payment (DSRIP) Program 7* (Aug. 2016), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/opt_out_process_faqs.pdf. While this publication pertains to the Delivery System Reform Incentive Payment Program within Medicaid, this program is in fact comprehensive, covering New York State’s six million Medicaid enrollees. *Id.* at 3.
- ²⁷⁹ *Id.* at 7.
- ²⁸⁰ *Id.*
- ²⁸¹ N.Y. Pub. Health Law §§ 2510-2511 (McKinney 2017).
- ²⁸² See N.Y. Pub. Health Law § 2510(7), (11) (McKinney 2017) (defining the scope of covered services).
- ²⁸³ N.Y. Pub. Health Law § 2511(2)(a)(iii) (McKinney 2017) (defining income eligibility levels for CHP as up to 400 percent of the federal poverty level); N.Y.S. Dep’t of Health, Child Health Plus, Eligibility and Cost (May 2016) (showing monthly income-eligibility levels by family size and what premiums apply at what income levels).
- ²⁸⁴ N.Y.C. Human Res. Admin., *Guide to Health Insurance and Health Care Services for Immigrants in New York City 1* (2016) (stating that Child Health Plus is available to “[a]ll children under 19, including undocumented children”), <https://www1.nyc.gov/assets/ochia/downloads/pdf/guide-to-health-insurance-for-immigrants.pdf>; N.Y. Immigration Coalition, *Welcome to Health Care! ¡Bienvenidos al Cuidado! 4* (2017) (same), http://welcometocup.org/file_columns/0000/0822/cup-welcome_to_health-care-mpp_pages.pdf.
- ²⁸⁵ Telephone interviews with Child Health Plus Helpline (800-698-4KIDS (1-800-698-4543)) and N.Y. State of Health Marketplace (1-855-355-5777) (July 7, 2017).
- ²⁸⁶ See *supra* Section VI (Medicaid).
- ²⁸⁷ N.Y. Pub. Health Law § 4903(2)(a) (McKinney 2017).
- ²⁸⁸ See *supra* note 277.



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