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Adolescents:

Medical Information Privacy and Consent for Treatment

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By: Stacy Stauffer, JD

Adolescents:
Medical Information Privacy and Consent for Treatment

INTRODUCTION

As a rule, adolescent patients cannot give consent for their own medical treatment before they reach the legal age of majority which, in most states, is 18. The circumstances in which adolescent patients can consent to their own medical treatment vary by state. However, most states have consent exceptions based on an adolescent's legal status (e.g., married, emancipated) and select medical conditions ("sensitive medical conditions").

Sensitive medical conditions are those for which adolescents presumably are less likely to seek treatment if doing so requires them to disclose the medical condition to their parents. Such circumstances might include treatment for sexually transmitted infections (STIs), pregnancy, family planning, substance abuse, and mental health.[1] The laws surrounding the privacy of sensitive condition treatment information vary, not only from state to state, but also among conditions.

Consent and confidentiality laws can provide a framework within which to consider a particular clinical situation. It is important, however, for clinicians to consider each adolescent consent and/or privacy issue on a case-by-case basis.[2] Many states allow clinician discretion in making a decision that is in the best interest of the adolescent patient.[3] Consequently, it is important to know the adolescent consent and privacy laws that apply in your state. It is also important to obtain sufficient information from parents and patients to counsel both parties in a manner that is consistent with clinical and ethical guidelines and furthers the patient's treatment goals. Should your decision-making ever be questioned or become the impetus for a lawsuit, documentation of the analysis leading to your consent and privacy decisions will be very important in the defense of claims against you.

A proactive approach to patient and parent education about changes to decision-making autonomy and privacy that occur at adolescence can reduce parent/adolescent/clinician conflict. It is important to remember that adolescent consent and privacy will be novel concepts for many patients and their parents. Providing educational materials, developing and adhering to adolescent consent and privacy policies and procedures, and encouraging open lines of communication can help set appropriate patient and parent expectations.

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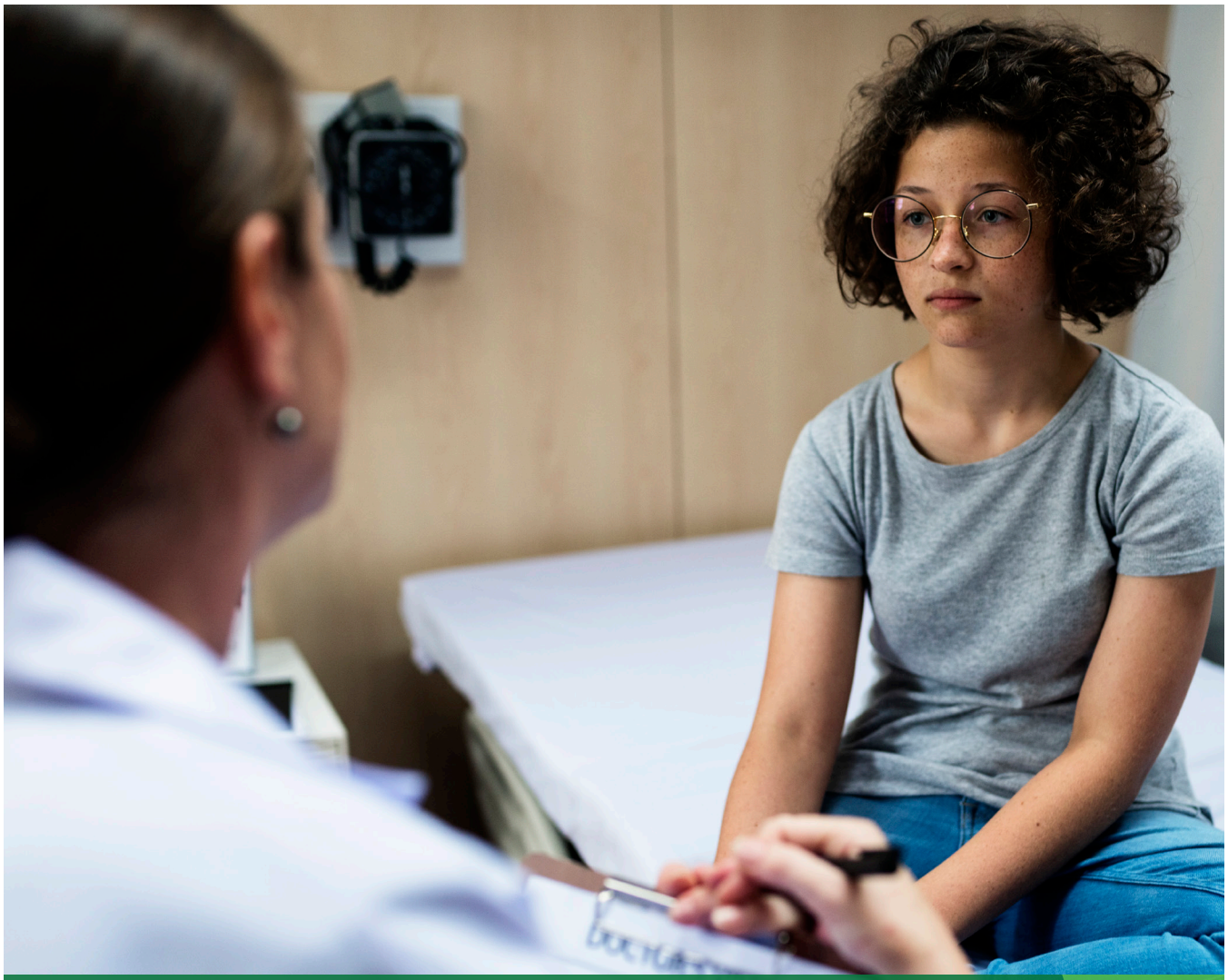

Treating Adolescents:
Challenges During the Consent Process

Practices that treat adolescent patients often find these areas challenging relative to obtaining consent:

- Drug testing
- Exams of private or sensitive areas
- Treating adolescent patients who come to their appointment unaccompanied
- Treatment of patients brought to their appointment by someone other than a parent or guardian (i.e., third-party consent)

The following case studies explore these challenges and offer risk reduction strategies. Due to the wide variations in state minor consent and privacy laws, the risk reduction strategies following these cases are general in nature.

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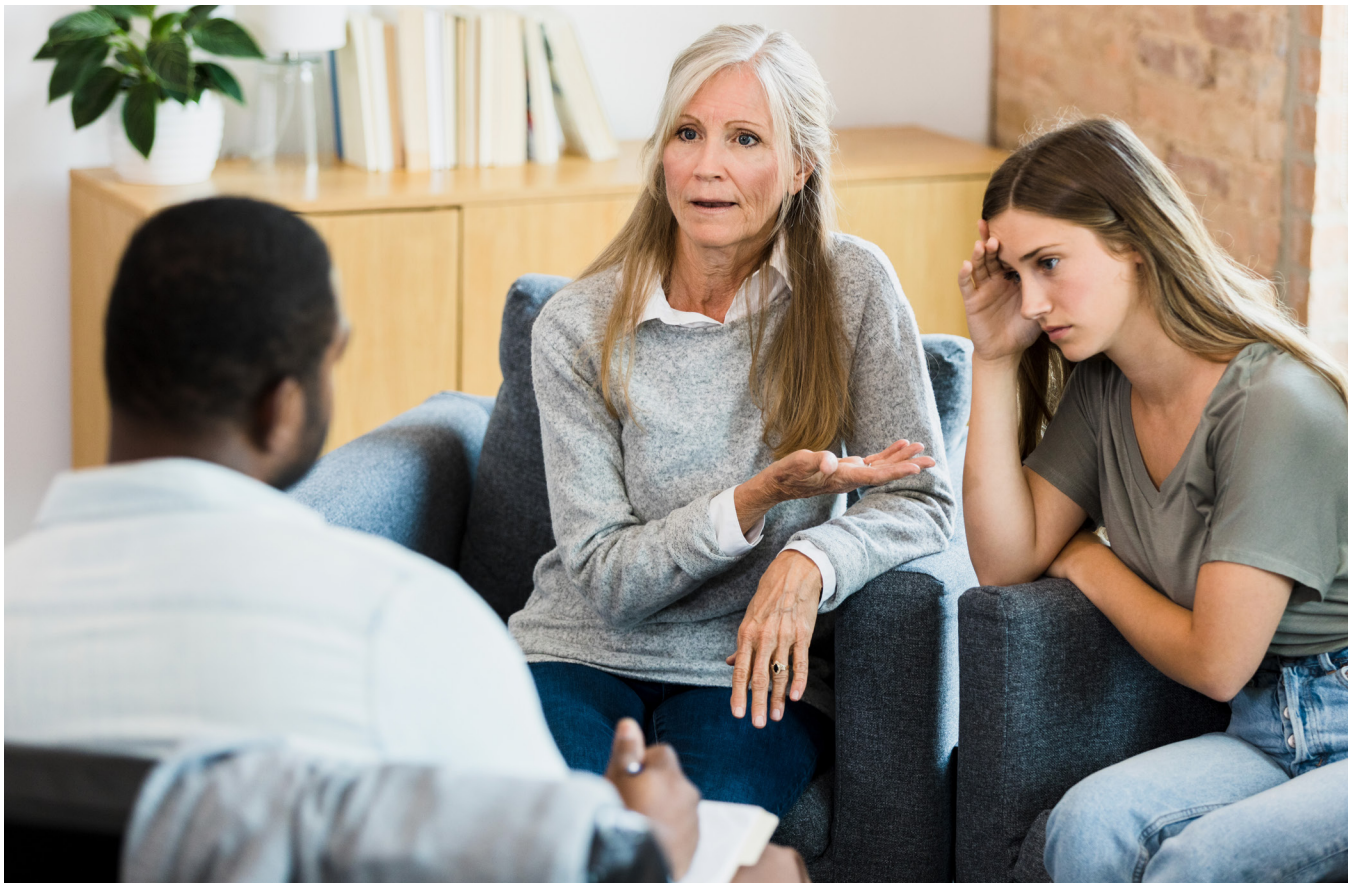

Drug Testing:

When Parents and the Adolescent Are at Odds

In most states adolescent patients have legal capacity to consent to substance abuse treatment. However, in a few states, parents have a right to seek substance abuse treatment for their child, even when the child objects. Further, some states allow providers to notify parents about treatment to which a minor has consented (or disclose information about the treatment), even without the minor's consent to disclosure.[4] Consequently, consent for diagnosis and treatment associated with substance abuse should be handled carefully. Consider the following case:

CASE ONE

Issue: A 15-year-old patient refused to submit to a drug test requested by her mother.

The mother of a 15-year-old patient called a family practice physician and asked him to perform a drug test on her daughter during an annual physical, even if the daughter refused to consent. The mother reported she had observed behavioral changes that indicated her daughter might be vaping and using drugs, although the daughter denied substance use. The mother planned to have her daughter enter a drug treatment program depending on the results. The physician called the Risk Management department to ask if he could comply with the mother's request.

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DISCUSSION

The answer to this question varies depending on the state in which a practice is located. Assuming the law in this state allowed the physician discretion in deciding whether to test without the minor's consent, there are many issues that play a role in his determination. For example, state law might allow parents to have a drug test performed on their adolescent child without the adolescent's consent. However, the American Academy of Pediatrics cautions against involuntarily drug testing adolescents except in emergency situations.[5] Also in this particular case the parents planned to admit their child to substance abuse treatment based on a positive result to one test. Their plan provided an opportunity for the physician to educate the parents about the limited value of a single test result. One result cannot indicate a pattern of abuse, dependence, or impairment, and might yield false-positive results.[5] Furthermore, a negative result would not rule out substance abuse.[6] The physician also had to consider the potential damage testing without the patient's consent would have on his therapeutic relationship with the patient. In this case the physician would have to determine which course represented the best interest of his patient.

RISK REDUCTION STRATEGIES

Consider the following strategies:[5,7]

- Know the minor consent laws about substance abuse diagnosis and treatment in the state in which you practice.
- Obtain a detailed description of the parents' concerns prompting the drug test request.
- Advise parents that a single positive drug test does not indicate substance abuse, and a negative test does not prove its absence.
- Discuss parental concerns with the patient without the parents present.
- When appropriate, document patient assent and permission to conduct the drug test and to share the results of the test before ordering the test.

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Unaccompanied Adolescents:

Does Old Enough to Drive Mean Old Enough to Consent?

As adolescent patients become drivers, they are more likely to present for treatment without a parent. Although a teenaged patient may seem mature enough to consent for general treatment, a parent's consent is still required. Consider the following case:

CASE TWO

Issue: A 17-year-old patient's parent requested that her teenaged son be permitted to provide consent for his own acne treatment.

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A dermatologist called the Risk Management department after a 17-year-old patient arrived without a parent for a six-month acne follow-up. The practice contacted the patient's mother and she consented to the treatment over the telephone. Since her child was able to drive himself to appointments, and she felt he was competent to consent to his own acne treatment, she asked if her son could continue acne treatment without her involvement. The dermatologist wanted to know how to accommodate her request and whether it was appropriate to obtain her consent over the telephone.

DISCUSSION

When an unaccompanied adolescent patient presents for nonurgent treatment, a parent's consent is necessary. In this example, because the parent and patient had an established relationship with the dermatologist, telephone consent from the parent to treat the adolescent for this simple follow-up appointment was sufficient. If during the appointment the dermatologist decided the patient needed treatment requiring informed consent (i.e., the mother needed to consider risks, benefits, and alternatives to determine whether she wanted her son to undergo the treatment), she would need to call the mother back to obtain full informed consent. Concerning the patient returning regularly without a parent, the dermatologist could obtain consent from the mother for the series of follow-ups if those appointments were not expected to involve new risks, benefits, and alternatives. However, if any of the future appointments involved treatment falling outside of the anticipated follow-up services (e.g., excision of a mole), the dermatologist would have to obtain separate consent to treat and, if necessary, informed consent.

RISK REDUCTION STRATEGIES

Prior to obtaining consent over the telephone for the treatment of an unaccompanied minor, or when obtaining consent for a series of treatments, it is important to establish a relationship with the patient and their parent(s). Parents should be told up front whether and under what circumstances their unaccompanied adolescent child will be treated. This can be accomplished by developing a written policy statement or handout that is provided to all parents whose children are approaching adolescence. For the treatment of unaccompanied minors, consider the following strategies:

Telephone Consent

- Verify the authenticity of the parent/guardian giving consent by requesting the patient's full name, date of birth, address, phone number(s), and details of the situation.
- If possible, have a second responsible person witness the call.
- Discuss the risks, benefits, and alternatives with the person authorized to consent as if they were present.
- Document in the minor's medical record who consented, who obtained the consent, and who witnessed it.
- Document that the consent was obtained by telephone.

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RISK REDUCTION STRATEGIES continued

Practical Tip

After verifying the authenticity of the parent or guardian by telephone and discussing the care and treatment, you may request that the parent/guardian provide documentation of their informed consent by email or fax. Have the legal representative giving consent send or affirm a message with words such as:

"I have been informed by Dr. X of the risks, benefits, and alternatives associated with the proposed treatment and grant permission for him/her to provide medical treatment [or a specific procedure or treatment] to [patient's name], [relationship to the patient]."

Attach a copy of the email or fax to the medical record. Whenever possible, original, signed consents should be obtained and filed in the medical record.

Consent for a Series of Treatments

- In a written policy or handout, clarify with parents what services may and may not be performed without explicit consent.
- Do not provide treatment outside the scope of the agreed-upon services without obtaining additional consent from the parent.
- Err on the side of caution.

Although some parents may expect it, only accommodate parents' requests to treat unaccompanied adolescents to your level of comfort and capabilities. Policies and procedures should be created and consistently adhered to throughout the practice to avoid confusion.

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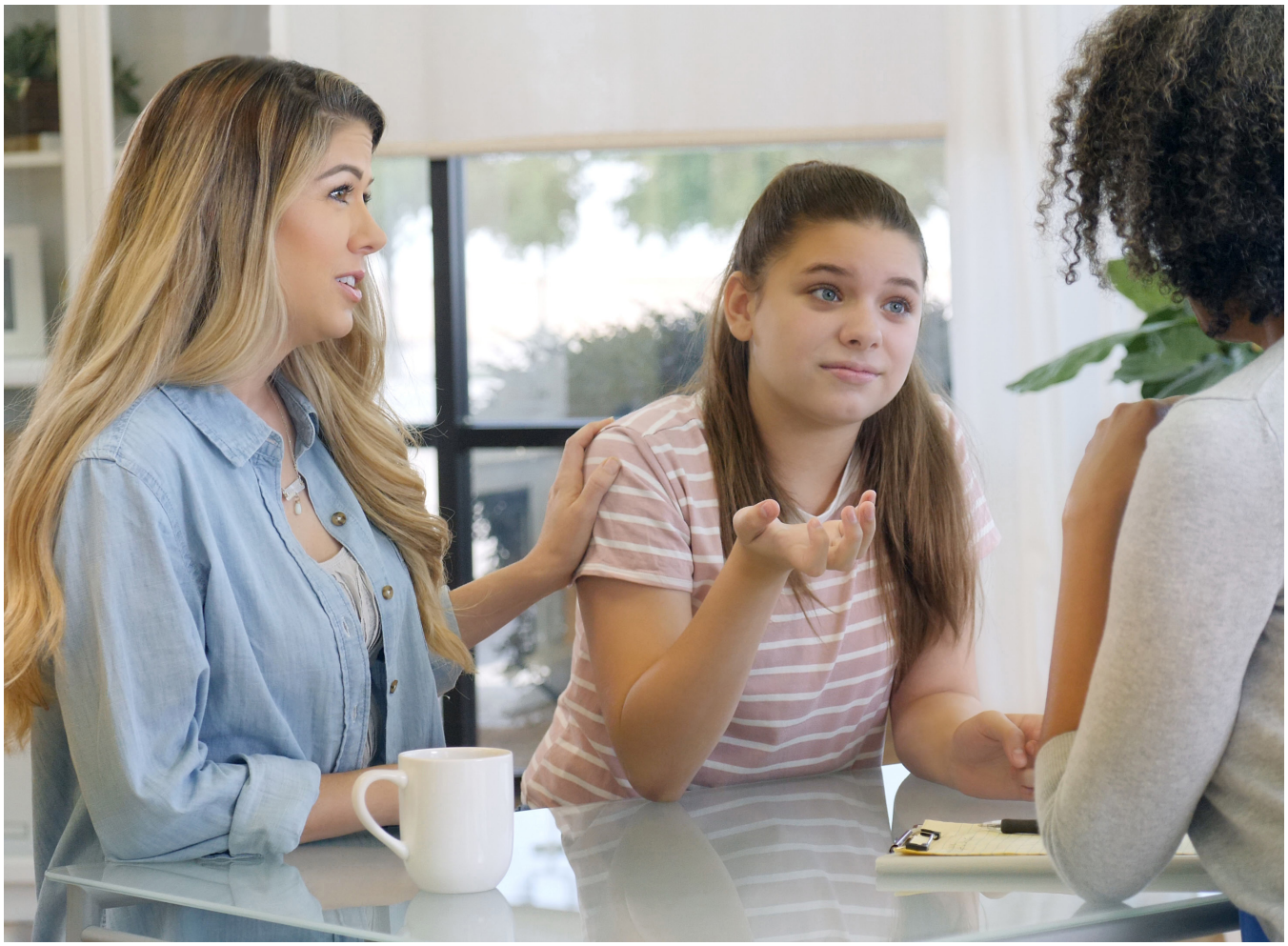

Third Parties:

Who Can Consent When Parents Are Unavailable

Many states allow third parties (e.g., relatives and nannies) to consent to a minor's medical treatment if the parent's/guardian's authorization is already in place. In these situations, a minor's parent/guardian may sign a statement authorizing a third party to consent to medical care if the minor's parents/guardians will not be available.

Clinicians can be tempted to bend the minor consent rules when the adolescent is older. Or the patient may come in with a relative who appears to be a caretaker, even though that caretaker does not have legal standing to consent to the adolescent's medical treatment. Consider the interests of the parties in the following case:

CASE THREE

Issue: A 16-year-old patient's caregiver was available to consent for treatment, but she was not a legal guardian.

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A child psychiatrist scheduled a new patient visit with a 16-year-old female. As part of the intake process, the physician learned that the patient resided with an aunt and that her parents' whereabouts were unknown. The physician was concerned about who could consent if the teenaged patient presented a need for prescribed psychotropic medications. Pursuant to state law, the aunt signed an affidavit allowing her to act as caregiver for the patient. Because the physician knew minor wards in the custody of the state required a court order to receive prescribed psychotropic medications, the physician wondered whether the aunt could consent under these circumstances. Consultation with Risk Management helped the physician determine that patients 15 years old or older in the state could consent to nearly all their own medical care, except for psychotropic medications. However, pursuant to probate and child welfare laws of the state, the caregiver affidavit permitted the aunt to consent to necessary medical treatment including "mental health treatment." Further, the same state law included protection against civil, criminal, or professional liability for a physician acting in good faith reliance upon a caregiver's authorization affidavit. Therefore, in this case the physician felt comfortable that if psychotropic medications were indicated for the new patient the aunt could consent on her behalf.

DISCUSSION

Unless an adolescent patient has a legal right to consent to proposed treatment, or there is a third-party authorization for consent on file for the person accompanying the minor, any nonurgent diagnostic and treatment decisions should be delayed until informed consent can be obtained from a parent/guardian.[8] In general, medical care that is "necessary and likely to prevent imminent and significant harm" to a minor patient can be provided if parental consent is not possible.[8]

Though the 16-year-old patient may have appeared mature enough to make general medical decisions independently, in this state she did not have the legal capacity to consent to treatment with psychotropic medications. (A limited number of states allow older adolescents to consent to general medical treatments based on various circumstances.) Some might argue that a 16-year-old patient is mature enough to consent to treatment with psychotropic medications. However, deeming older patients mature enough to consent to general medical treatment as a practice policy is unwise.[8] Additionally, many states shift financial liability to the adolescent when the adolescent has consented to the treatment. Therefore, if it is appropriate for an adolescent patient to consent to anticipated treatment without parental involvement or knowledge, payment issues should be addressed up front with the adolescent.

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RISK REDUCTION STRATEGIES

Careful planning and sound office policies and procedures can help prevent situations where clinicians and staff will be tempted to treat an adolescent patient without proper consent. Consider the following strategies:[8,9]

- Review state laws related to third-party consent for minor healthcare, and only adopt policies and procedures consistent with those laws.
- Make a practice-wide determination about whether third parties will be allowed to consent to adolescent patient non-emergent care and create a policy consistent with that determination. (If all physicians within the practice do not adopt the same policy, problems can arise during coverage arrangements.)
- Educate physicians and staff about third-party consent policies and procedures.
- If the practice will allow third-party consent, create a third-party consent policy that includes:
  - How to determine whether the person requesting it can delegate consent (e.g., what documents must be provided by a guardian or a divorced parent to prove their right to delegate).
  - Which third parties can be delegated the power to consent.
  - The method by which clinicians/staff will ensure the identity of the authorized third party:
    - Consider requesting a signature and photo ID from the third party.
  - The circumstances under which a third party can/cannot consent (e.g., you might honor third-party consents when there is a scheduled absence of a parent, such as vacation or business travel, but not for unscheduled absences).
    - When the need for third-party consent appears likely, arrangements should be made for the parent/guardian to provide a written preauthorization.
  - The services for which the third party can/cannot consent (e.g., preventive care, allergy shots and immunizations, but not x-rays or other diagnostic tests).
  - The frequency with which third-party consents must be updated.
  - Documentation requirements for compliance with the policy.
- If there are specific circumstances for which third-party consent cannot be given, ensure that they are clearly indicated in the patient's record.
- Consider creating a template form that can be used for third-party consent. The American College of Emergency Physicians Consent for Medical/Surgical Care/Emergency Treatment and Child's Medical Information[10] may be helpful as a sample.
- Store authorization documents in an easily accessible location in the patient's record.
- Clearly communicate third-party consent policies and procedures to parents and adolescent patients, preferably in writing.
- Document in the minor's medical record who is consenting to the treatment on behalf of the minor and the basis on which the consent is appropriate (e.g., parent, guardian, legal status of minor). Also document the manner in which the consent was obtained (i.e., if not in person, then by telephone, fax, or email).

Even when a third-party consent authorization is in place, it's wise to attempt to contact the parent(s) to confirm consent and update that person about the minor's status. This is particularly wise when the patient is being treated for an injury.[11]

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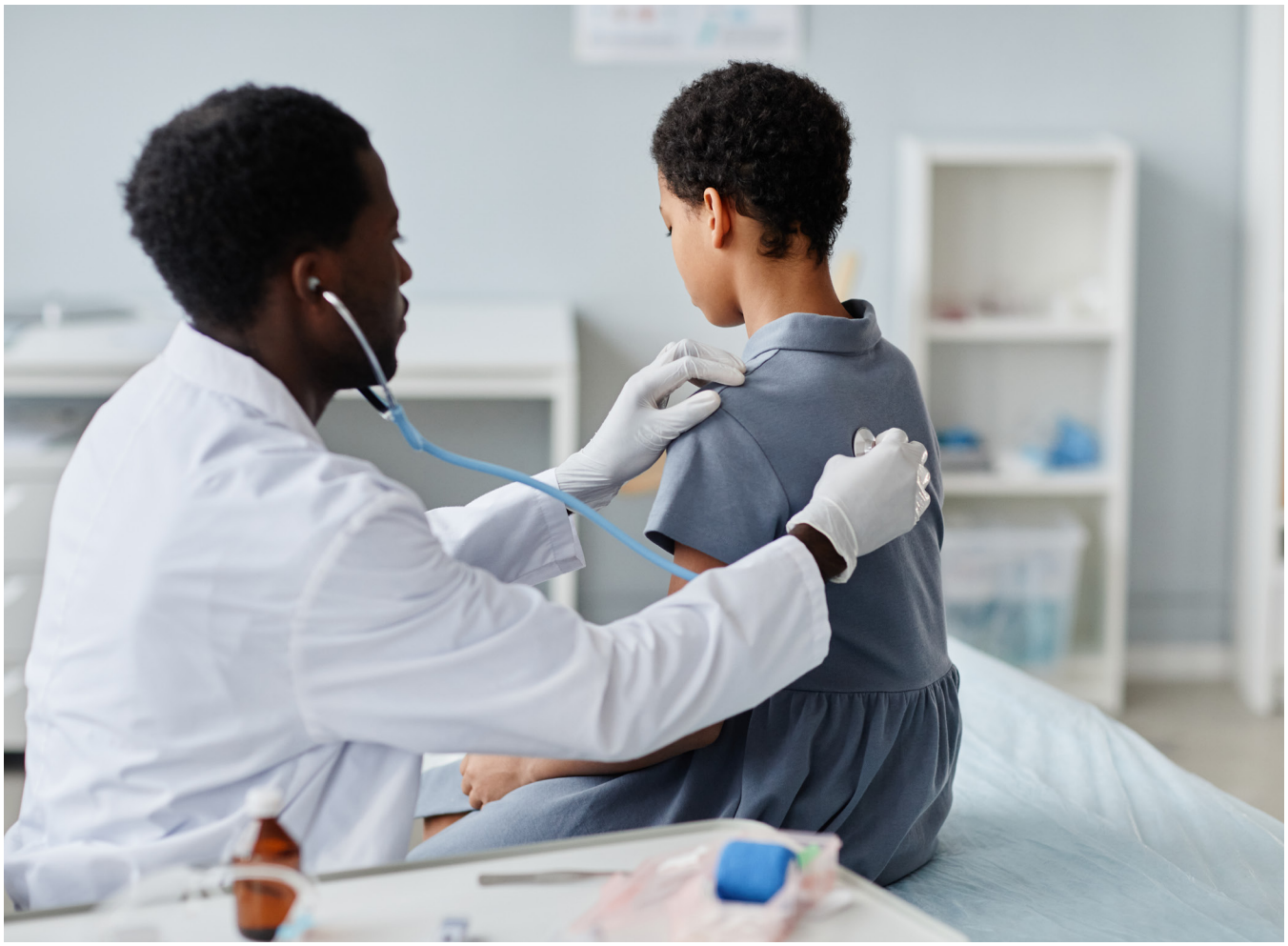

Sensitivity Matters:

Helping the Adolescent Patient Feel Safe

Teenagers experience rapid change both physically and socially during adolescence. They may not always be comfortable in their bodies or understand all of these changes. Younger teens especially may be experiencing their first feelings of romantic or sexual attraction or perceiving themselves as the objects of such attractions. They may be uncomfortable or unsure how to react when a routine medical examination involves intimate parts of their bodies. Consider the following case:

CASE FOUR

Issue: An external genital examination on a 13-year-old patient with flu symptoms was not well explained, resulting in allegations of inappropriate conduct.

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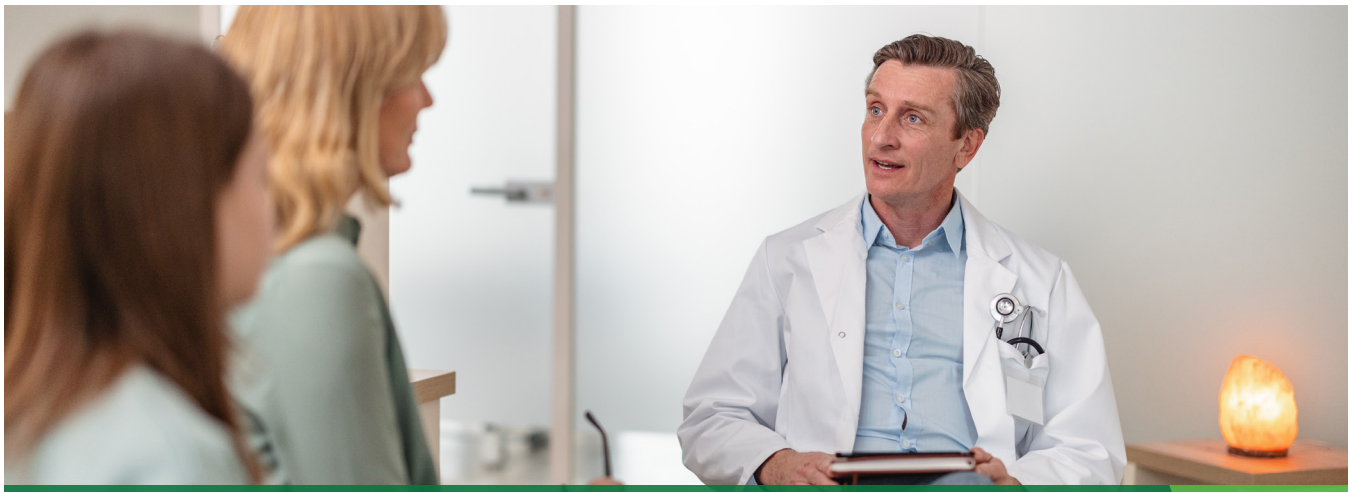
A 13-year-old female accompanied by her father arrived at an urgent care practice for an appointment to evaluate her worsening flu-like symptoms. After a nurse placed her in an exam room, the patient changed into a gown. (Her father would remain in the room with her during the entire exam.) The physician entered and explained his intent to complete a head-to-toe examination, then checking the mucous membranes of the patient's eyes, nasopharynx, and oropharynx; and then proceeding to listen to the patient's heart, lungs, and bowel sounds while she was seated on the exam table. Requesting the patient lie down on the exam table, the physician then palpated her abdomen and subsequently conducted an external genital examination. No chaperone was offered, and the physician did not wear gloves. Later in the afternoon the patient's mother called, asked why no female chaperone was offered, and filed a complaint with the county sheriff's department. While no charges resulted from the incident, the practice prevented the physician from seeing patients while the matter resolved itself.

DISCUSSION

While no charges resulted from this encounter, a more sensitive and empathetic approach toward the young patient may have prevented the situation from escalating as it did. Adolescence is a time of great transition, and many young people are mystified, alarmed, or embarrassed by changes in their bodies. Most children are also taught very early on that strangers should not touch them in private areas without permission. (See for example the "swimsuit rule."[12]) A physician may look at such an exam in a strictly clinical way, but for a young teenager it may feel violating. Had the physician in this scenario paused prior to the genital exam and explained what the exam would entail, why it was necessary for flu symptoms, and asked permission to touch the private area, the patient may have felt more comfortable. Further, had the physician worn gloves, this may have enhanced the clinical nature of the sensitive exam. Finally, offering a chaperone for such an exam might have enhanced the patient's sense of safety and affirmed her consent.

RISK REDUCTION STRATEGIES

- Consider that an adolescent may have not experienced the exam you are about to conduct. Explain how and why the exam is necessary and ask permission before touching.
- Wear gloves during any exam involving private/sensitive areas of the body.
- Offer a same-gender chaperone and document their presence including details like name and job title, or why a chaperone was not utilized.



Adolescent Health Information Privacy:
Federal and State Laws

In addition to minor consent laws, clinicians treating adolescent patients should be familiar with state and federal medical information privacy laws as they relate to adolescent healthcare. They should develop clear policies and protocols for appropriately protecting this confidential information. Adolescent privacy laws vary in significant ways from state to state, and may conflict with federal laws.[4] Federal law may impact whether an adolescent's sensitive healthcare information can be shared with parents.[13,14] For example, Title X legislation requires that confidential services be available to adolescents seeking care in Title X-funded family planning programs.[1] Despite legal privacy requirements, clinicians have a limited ability to control adolescent sensitive treatment information that is provided to parents by their health insurers. Consequently, any time an adolescent seeks treatment under a parent's health insurance there is a good chance the parent will learn about it by way of an explanation of benefits (EOB) form. This may occur unless the insurer can be persuaded to accommodate the patient's privacy request.[14] It is worth noting, however, that several states have passed or proposed legislation related to increasing confidentiality protections regarding health insurance payment and billing.[14]

A full discussion of the interplay between federal and state privacy laws concerning the treatment of adolescents is beyond the scope of this article. Online information is available from various sources, for example:

- United States Department of Health and Human Services: Personal Representatives[15]
- Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process[16]

ADOLESCENT MEDICAL INFORMATION PRIVACY: PATIENT AND PARENT EDUCATION

Every practice should have policies and procedures associated with adolescent privacy, and every person in the practice should understand them and apply them consistently. When a child reaches adolescence, or when the practice accepts a new adolescent patient, it is important to educate the parent and patient about the practice's medical information privacy policies and procedures. This education would include the limits to confidentiality: for example, confidentiality may be intentionally breached if the adolescent poses a threat to themselves or others. Further, billing policies, medical records, and appointment notifications can inadvertently compromise confidentiality.[7]

Sending patients and parents a letter describing the practice's adolescent patient confidentiality policy can set expectations prior to the patient's first appointment as an adolescent. This information may be included in one letter, or the practice may choose to send separate letters. The letter(s) can also be posted on the practice website, given to the parent/patient again following the appointment, and provided as a handout in the waiting room. The letter should validate the parents' role in their adolescent's healthcare decision-making. It should also outline the clinician's role in fostering increased patient autonomy in healthcare decision-making in preparation for adulthood.[7]

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RISK REDUCTION STRATEGIES

Consider including the following issues in a patient/parent informational letter and reiterating these points in personal discussions with the parent and patient:[7,16,17]

- Describe the effect that consent and privacy laws will have on both the treatment of adolescent patients in your practice and parent access to medical information.
- Outline limits on privacy protections. For example:
  - Parents will be contacted if patients pose a threat to themselves or others.
  - Physicians are required to report certain sexually transmitted diseases and suspicion of physical or sexual abuse.
  - Health insurance documents and office billing can inadvertently breach confidentiality.
- Explain your policies on privately interviewing and examining adolescent patients.
- Having adolescent patients communicate with parents and involve them in important healthcare decisions is ideal. Sometimes, however, adolescent patients may opt for no treatment if their parents will find out about it.

When discussing confidentiality with adolescent patients, consider including the following points: [7,16,17]

- Explain that their parents will probably see some information about confidential services on EOBs, if they are using their parent's health insurance.
  - Ask the respective health insurer about its notification procedures and pass this information on to the patient.
  - Encourage the patient to contact the insurance company to request that sensitive treatment information not be provided to the policyholder via EOBs.
  - Discuss with the adolescent patient how they should be contacted for treatment of sensitive conditions. Ensure the adolescent's email and cell phone contact information is on file and there is a system in place to alert staff to use these methods of contact when appropriate.
- Although it may be unlikely that adolescent patients can afford to independently pay for treatment, give them the option when there is a risk of inadvertent disclosure by third parties. If patients do pay for treatment, ensure bills and other payment information are not sent to their parents.

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Is it Confidential?:

Adolescent Autonomy vs. Parents' Need to Nurture, Guide, and Protect

The Risk Management department often gets calls describing adolescent treatment scenarios that do not neatly fit into one of the sensitive treatment categories. These situations often require the clinician to weigh the adolescent's need for autonomy against the parents' need to nurture, guide, and protect their child. When the line between what can and cannot be shared with a parent appears legally ambiguous, a physician's discretion is often the best solution. Consider the following two calls:

CASE FIVE

Issue: A 16-year-old patient requested her weight remain confidential.

A 16-year-old patient with intractable anorexia nervosa wanted her pediatrician to keep her weight confidential from her parents. The pediatrician called the Risk Management department to ask if he could honor the patient's request.

CASE SIX

Issue: A 17-year-old patient requested his treatment for genital numbness remain confidential.

A 17-year-old patient came into the pediatrician's office advising that his parents were out of town, and he was having intercourse and developed pain and numbness in his penis. The pediatrician told him to ice it and go to the emergency department if he had no relief. He then called the Risk Management department to ask if he should advise the parents of the treatment he had provided to their son.

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DISCUSSION

The need to notify parents in these two cases could be argued either way. For example, opinions may differ about whether intercourse-related penis pain is related closely enough to family planning services or STI treatment to withhold notification of the patient's parents about his treatment. Similarly, an adolescent's weight is not the type of medical information that usually triggers confidentiality. However, because the patient is being treated for a mental health condition that is significantly associated with her weight, the patient's weight may have become confidential under the circumstances. State laws rarely contain the detail necessary to provide guidance for every clinical situation. Most states with parental notification laws related to the provision of sensitive condition treatment permit clinicians to use their discretion as to whether a patient's parent should be notified of sensitive treatment.[3,7] For example, if the parents of the patient in case five did not know their daughter had anorexia, breaking confidentiality could be justified. This is not only because anorexia can be life threatening, but also because family therapy may be in the patient's best interest.[17] However, in the case described above the patient, parents, and pediatrician may have been able to come to an agreement about whether reporting the patient's weight to her parents was necessary to achieve the patient's treatment goals. Similarly, the pediatrician in case six would have to determine whether the benefits of parental notification outweighed the risks. In case six, the insurance EOB would most likely alert the parents to their child's visit to the pediatrician. That pediatrician, if he decided the information should be shared with the parents, could limit the details and leave it to the patient to explain to the parents how the penis pain occurred.

RISK REDUCTION STRATEGIES

Because every treatment situation is unique it is important to carefully consider how breaching or sustaining confidentiality will affect your treatment goals for a particular adolescent patient. Consider the following questions in your analysis:[3,18]

- Does the patient have a life-threatening problem?
- Will breaking confidentiality irreparably damage the therapeutic alliance?
- Will a break in confidentiality put the patient in danger? Will a third party most likely provide the treatment information to the parents?
  - If the patient is advised of these concerns, they can be counseled about how to talk to their parents about the treatment before they are surprised by a third party.
  - The patient can also be given information about contacting their parents' health insurer to determine whether the insurer will uphold confidentiality.

Once your decision is made there are additional strategies to minimize the negative aspects of maintaining or breaking confidentiality. Consider the following recommendations:[3,18]

- When telling a parent about otherwise confidential information, disclose the least amount of information possible for necessary shared decision-making.
- If you decide to allow autonomy and maintain confidentiality, also provide age-appropriate decision-making support.
- Adequately document the reasoning that went into your decision-making autonomy and privacy determination.
- When the situation calls for your discretion, appropriately document the risk-benefit analysis that went into your decision-making autonomy and privacy decision.

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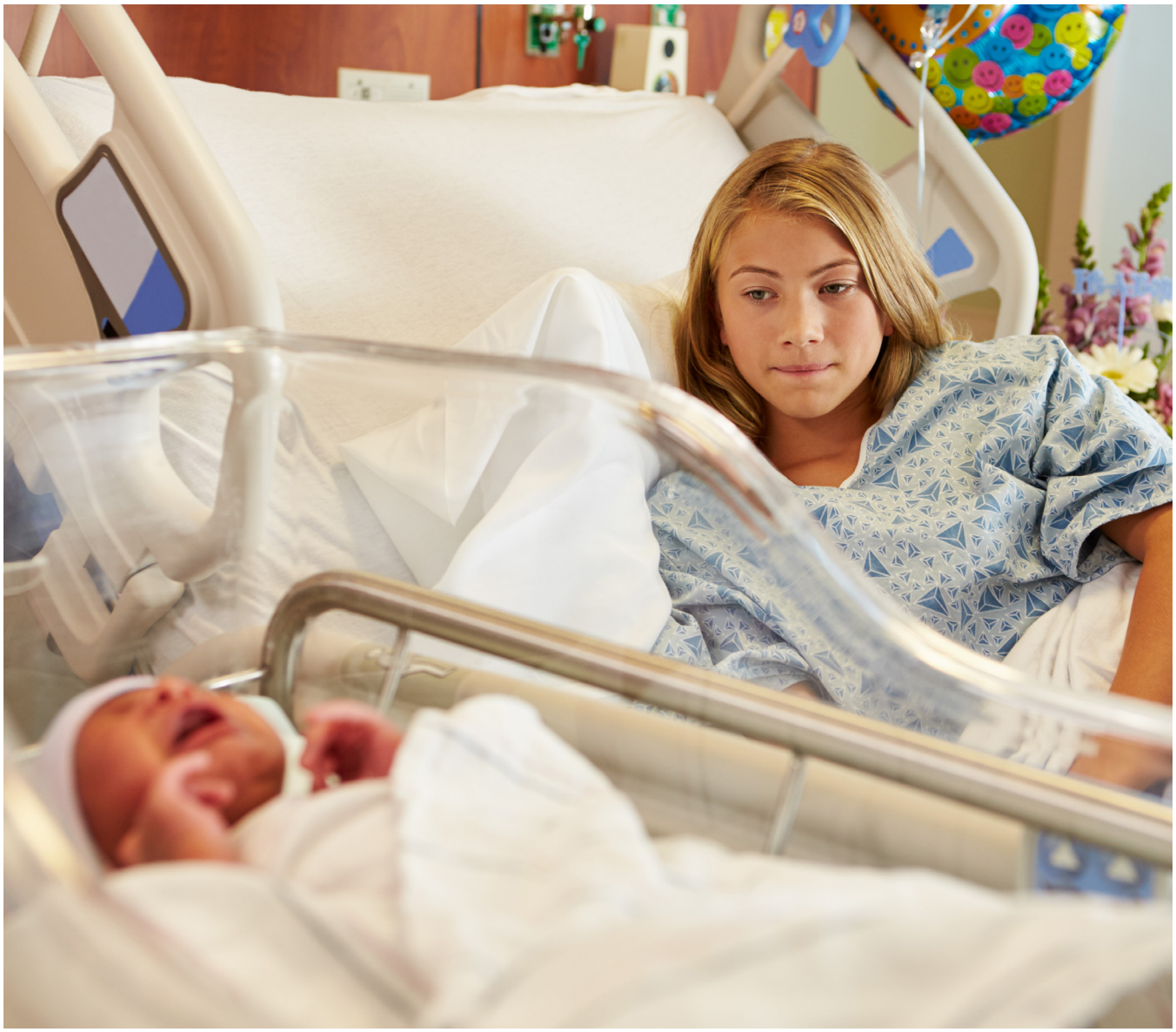

More Wrinkles in Adolescent Consent:

When Teen Patients are Parents

CASE SEVEN

Issue: A 16-year-old new mother's ability to consent to her newborn's treatment was unclear.

A 16-year-old female in the 40th week of her first pregnancy arrived at the labor and delivery department of a hospital. The patient's boyfriend whom she lived with in an apartment, and her mother who lived separately, accompanied her to the hospital. After fifteen hours of labor the patient required an emergency Cesarean section and delivered a 7-pound 12-ounce baby girl. After initially poor Apgar scores the baby received emergency care from the NICU team and remained hospitalized for several months.

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DISCUSSION

Even the limited facts of this case expose the labyrinth of state laws that determines how adolescent consent functions for situations like prenatal and postnatal care. In some states, the fact that the birthing mother lives independently from her own mother allows her to make decisions concerning her own care. In other states, though all the other facts from case seven remain consistent, the mother of the pregnant minor would need to consent to all treatments on her behalf. Whether the minor is married can also impact the consent status. Other states determine whether the minor can consent to her own care based on the stage of the pregnancy. Whether or not the minor mother can consent to her own medical care and that of her new baby most often rests with the minor mother and the father. Some states, however, have no policy or law addressing the issue. There are even states that allow a minor parent to consent to medical care for themselves or their child, where a minor of the same age but childless would need parental consent.

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CONCLUSION

Adolescent autonomy and privacy are affected by a tangled web of state and federal laws by which clinicians are expected to know and abide. With these laws as a guide, the process of working through the sometimes competing interests of adolescents and their families should focus on promoting the well-being of the adolescent patient.[2] Therefore policies and procedures should be consistent with the laws but allow some flexibility to accommodate unanticipated scenarios. Proactive conflict management during this brief period in the patient's healthcare journey is accomplished through parent and adolescent patient education about changes that occur in patient autonomy and privacy at adolescence. This education can diminish stress and frustration for patients, parents, and clinicians. When in doubt about an adolescent issue, a physician or other practitioner can look to the Risk Management department or contact a healthcare attorney for legal advice about their own state's laws.

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ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

Some content in this article was previously published in "Adolescents, Their Parents, Consent, and Privacy," *Claims Rx* (June 2020), https://www.norcal-group.com/claimsrx/adolescents-parents-consent-privacy.

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