Understanding Minor Consent and Confidentiality

UNDERSTANDING MINOR CONSENT AND CONFIDENTIALITY IN COLORADO

Sample Consent and Release Forms

COLORADO ASSOCIATION FOR
SCHOOL-BASED HEALTH CARE

CONTENTS

ACKNOWLEDGEMENTS

These sample consent and release forms were researched and developed by Rebecca Gudeman, Senior Attorney at the National Center for Youth Law and Melinda Gonzales, Director of Adolescent Programs at the Colorado Association for School-Based Health Care.

INTRODUCTION

Attached you will find five sample consent and release forms for use in school health programs. The sample forms provided include the following:

Form A: Consent to Medical Treatment
Form B: Minor Consent to Medical Treatment
Form C: Authorization to Release Health Information (HIPAA compliant)
Form D: Minor's Authorization to Release Health Information (HIPAA compliant)
Form E: Consent for Release of Education Records (FERPA compliant)

All sample forms are provided for reference purposes only. Before using or adapting these forms, they should be reviewed with local counsel to confirm they are in compliance with applicable law and policy. They also should be reviewed and adapted for individual use to take into account, among other things:

- The services your school based health program provides
- Your community partners and partnerships
- Local policies and strategies
- Community specific concerns
- Community literacy and language needs

Forms C, D and E comply with HIPAA and FERPA. However, if your program provides services that may be subject to additional confidentiality and release regulations, such as Title X funded family planning services or certain drug treatment services, you should review these forms with legal counsel and adapt to conform to the applicable confidentiality law. If your health program shares information between agencies subject to different laws, two types of release forms may be necessary for information to be shared in both directions. (For example, a SBHC subject to HIPAA must receive a HIPAA compliant form in order to release information to a school in many cases, and the school must receive a FERPA compliant form in order to release information back to the SBHC.)

If your school health program is subject to HIPAA, consider the following sample forms as a reference:			
Form	Allows for:	Signed by:	Written documentation required?
Form A: Consent to Medical Treatment	Provision of ordinary health services offered by the health program excluding minor consent services	Parent or Guardian	No, but often recommended. Consult legal counsel.
Form B: Minor Consent to Treatment	Provision of minor consent services excluding ordinary health services offered by health program	Minor	No, but often recommended. Consult legal counsel.

Form C: Authorization to Release Health Information	SBHC subject to HIPAA to release individually identifiable health information to an outside party when no exception* in HIPAA otherwise allows the disclosure	Parent or Guardian	Yes
Form D: Minor's Authorization to Release Health Information	SBHC subject to HIPAA to release individually identifiable health information for which a minor consented when no exception* otherwise allows the disclosure	Minor	Yes
Form E: Consent for Release of Education Records	School to release individual information from the education record to the SBHC when no exception* in FERPA otherwise would allow the disclosure	Parent or Guardian	Yes
If your school health program is subject to FERPA, consider the following sample form as a reference:			
Form	Allows for:	Signed by:	Written documentation required?
Form A: Consent to Medical Treatment	Provision of ordinary health services offered by the health program excluding minor consent services	Parent or Guardian	No, but often recommended. Consult legal counsel.
Form B: Minor Consent to Medical Treatment	Provision of minor consent services excluding ordinary health services offered by health program	Minor	No, but often recommended. Consult legal counsel.
Form E: Consent for Release of Education Records	SBHC subject to FERPA to release individual information in its file when no exception* otherwise allows the disclosure	Parent or Guardian	Yes

* In many cases, exceptions in HIPAA and FERPA allow a SBHC or educational agency to share information without need of an authorization. These exceptions are described in the *Understanding Minor Consent and Confidentiality in Colorado Toolkit*.

INSTRUCTIONS FOR FORM USE AND ADAPTATION

1. Consent to Medical Treatment Forms: Sample Forms A and B

It is important to know that nothing in state or federal law requires that health care providers obtain **written consent** before providing ordinary health care services, with only a few exceptions typically not applicable to the school health setting. While verbal consent is sufficient, health care providers and their legal counsel may choose to make written consent a part of their standard practice. School health providers should consult legal counsel for further information on consent and when written consent is advisable, as well as for assistance adapting these forms.

- ***Form A:***

While you should review the entire form carefully and make adaptations as appropriate, we want to highlight a few sections that merit careful review:

Bullet point 1: If you use Form A as a basis for your own form, the services described in bullet point 1 should be adapted for your own program to specifically include or exclude services offered by your program. The list provided serves only as an example.

Bullet point 3: This form includes a default expiration date of one year. The benefits and drawbacks of different expiration dates or events should be discussed with legal counsel.

Bullet point 4: This bullet should be adapted to reflect your clinic's billing practices, which may include collection of insurance information. Nothing in the law requires providers to include this information on a consent form. The benefits and drawbacks should be discussed with legal counsel.

- ***Form B:***

Minors may consent to medical services on their own behalf in some cases. This form is only relevant if your school health program offers any "minor consent" services or sees students who may qualify to consent for care based on their status. See the notes under *Form A* for general guidance on consent forms.

A quick summary of minor consent laws is provided below. See the *Understanding Minor Consent and Confidentiality in Colorado Toolkit* for more detailed information on the minor consent laws in Colorado.

COLORADO MINOR CONSENT LAWS – Quick Reference Chart[1]	
SERVICES YOUTH CAN OBTAIN ON THEIR OWN	
Family Planning Services Funded by Title X[2] • Includes (among others) contraception, STD testing, and breast and pelvic examinations.	Minors of any age
Prenatal, Delivery, and Post- Delivery Care • Medical care related to the intended live birth of a child.	Pregnant minors of any age
Contraception • Birth control procedures, supplies, and information. • This does not include sterilization	Minors of any age who request and need birth control
Sexually Transmitted Infections • Diagnosis and treatment	Minors of any age
HIV • Diagnosis and treatment	Minors of any age
Treatment after Sexual Offense (Sexual Assault) • Examinations, prescription and treatment of victim for any immediate condition caused by a sexual offense • For this purpose, "sexual offenses" include (but are not limited to) sexual assault, sexual assault on a child and unlawful sexual contact as defined by Colorado law.	Minors of any age
Mental Health Treatment • Includes outpatient treatment • Minors cannot consent to electroconvulsive treatment	Minors 15 years of age or older
Alcohol / Drug Abuse Treatment • Includes treatment for addiction to or use of drugs, emergency treatment for intoxication, and treatment for alcoholism.	Minors of any age

[1] For more information and detail about these laws, see the companion tool entitled "*Colorado Minor Consent Laws*." Remember that consent and confidentiality are different concepts. For more information on confidentiality laws, see the tool entitled "*Confidentiality of Adolescent Medical Records under Colorado Law.*" Both companion tools can be found in the *Understanding Minor Consent and Confidentiality Toolkit*.

[2] The Title X Family Planning Program is part of the federal Public Health Services Act. For more information on Title X family planning services and Title X funded providers in Colorado, go to www.cdphe.state.co.us/pp/womens/famplan.html.

2. Authorization to Release Health Information: Forms C and D

Health care providers subject to HIPAA must have written authorization to share individually identifiable health information about a patient unless an exception in HIPAA applies and lets them share without that authorization. The *Understanding Minor Consent and Confidentiality in Colorado Toolkit* describes some of the exceptions in HIPAA that allow school based health programs to share information without an authorization. There are many exceptions; however, there will be times a provider needs a written authorization in order to share information with an outside partner. HIPAA requires authorization forms to include certain elements and notices to be valid. Forms C and D satisfy the HIPAA requirements. If you hold information protected by other law in addition to HIPAA, such as information protected by Title X regulations, Forms C and D may not meet all legal requirements for release of information. You should speak to legal counsel about how to adapt these forms for other uses.

- ***Form C:***

Parents and guardians generally control the release of health information about their minor children. For more information on exceptions to this rule, see the toolkit and consult legal counsel. Youth who are 18 or older control release of their own health information. This form should be used when adult youth or a parent, guardian or other legally authorized third party is signing to release a minor patient's health information. While you should review the entire form carefully, we want to highlight a few sections that merit careful review:

Introduction: HIPAA requires an authorization to include a description of the purpose for disclosure. This form meets this requirement in the introduction. You should speak to legal counsel before adapting or removing any language.

Bullets 1 and 2: If you use Form C as a basis for your own form, the services described in bullet point 1 and the partners described in bullet 2 should be adapted for your own program.

Bullet 3: HIPAA requires this form to include an expiration date or event.

Notices: HIPAA requires authorizations to include certain notices. You should speak to legal counsel before adapting or removing any language.

- ***Form D:***

If a minor consents to his or her own care, the HIPAA regulations state that the minor must authorize disclosure of the related records. The minor also must sign the authorization in a few other situations; for example, the minor must sign if a court consented for the minor's

medical care pursuant to state law or the parent or guardian assented to an agreement of confidentiality. This form should be used when a minor must authorize release of records. See the notes under *Form C* for general guidance.

3. Consent to Release Education Records: Form E

Educational agencies whose records are subject to FERPA typically must have a signed consent in order to release records from the education file. To be valid, FERPA requires authorization forms to include certain elements. Form D satisfies the FERPA requirements. This form allows sharing of educational records. It does not allow a HIPAA entity to share personally identifiable health information with the educational agency.

4. Additional Information: Combining or Merging Forms into One Document

Many providers want to merge their consent to treatment and authorization to release information forms into one document. Providers should consult legal counsel before merging any of these forms. There are many reasons to be careful and to seek legal advice before using a merged form, but just one reason is that HIPAA deems an authorization ” invalid” if it can be considered a “*compound authorization.*” Combining an authorization with another document can create a “*compound authorization*.” Legal counsel can help providers ensure they do not violate this HIPAA prohibition against “*compound authorizations*.”

Consent to Medical Treatment
at [*insert name of school health clinic or provider*]

Please read this form carefully and provide all the requested information to allow your child to receive health services at school.

Student/Patient Information

Name:_____ Date of birth:_____ Grade:_____
Address:_____
Cell Phone:_____ Email:_____

1. **I GIVE PERMISSION FOR [INSERT NAME OF HEALTH CARE SERVICES PROVIDER OR CLINIC]** to provide any of the health and mental health care services listed below to my child during the following year, when advised or recommended by [*insert name of health care services provider or clinic*] staff.

TYPE OF SERVICES:
Diagnosis/treatment of minor and acute illnesses, including first aid for minor injuries
Assistance with chronic (on-going) illnesses
Routine physical examinations, including exams for sports or pre-employment clearance
Immunizations
Routine laboratory services
Dental screening and application of fluoride varnish
Vision and hearing screenings
Over-the-counter and basic prescription medications
Health and wellness education
Mental health services, including screening, assessment, and counseling
Referrals for health services which cannot be provided at this clinic

2. **I UNDERSTAND THAT I CAN CHANGE MY MIND LATER** on and decide I do not want my child to get services at [*insert name of health services provider or clinic*]. If I change my mind, I will let [*insert name of health services provider or clinic*] know in writing by sending a letter to the following address:[*insert name and address of health care services provider or clinic*].

3. I understand that this consent form remains valid for one year, until the following expiration date _____, or until the clinic receives a written revocation from me.

4. **I UNDERSTAND THAT** [*health care services provider or clinic*] needs to cover its expenses. I agree to allow [*insert name of health care services provider or clinic*] to bill any applicable health insurer. I will provide my insurance information below. If I do not have insurance, I agree to discuss my family's eligibility for available public insurance programs or sliding fee scale options with [*insert name of health services provider or clinic*].

Signature of Parent/Legal Guardian:_____ Date:_____

Print Name of Parent/Legal Guardian:_____

Parent/ Legal Guardian Contact Information
Address:_____
Home Phone:_____Cell:_____Work:_____
Email:_____

Insurance Information:

Name of Health Insurance: _____
Health Insurance Address: _____
Health Insurance Phone: _____

Policy #/Medicaid # (if applicable):_____ Insurance Effective Date:_____

Name of Insured:_____

Race (Mark all that apply): ___White
___Black or African American
___American Indian/Alaska Native
___Asian/Pacific Islander

Ethnicity (check one): _____Hispanic/Latino _____Non-Hispanic/Non-Latino

Number of people in Family: _____ Family Income: _____

Primary Language Spoken at Home:_____

Minor Consent to Medical Treatment at [*insert name of school health center*]

[*Insert name of health services provider*] provides health care services to students at [*insert name of school*]. Under Colorado law, youth may be able to consent to their own health care because of their status or living situation. Youth under age 18 also may consent to receive certain health care services on their own, often called "minor consent" services. Some examples of "minor consent" services include mental health counseling; treatment for addiction; diagnosis and treatment of sexually transmitted diseases; and contraception. We provide or can refer you for this care. If you would like more information about whether you qualify for this care and the services we provide, please talk to us. If you are interested in consenting to your own care, please complete this form.

Student/Patient Information

Name:_____ Date of birth:_____ Grade:_____
Address:_____
Cell Phone:_____ Email:_____

1. I am able to consent to my own care because:

   [ ] I am 18 years old or older.
   [ ] I am married or have been married.
   [ ] I am 15 years old or older, living separate and apart from my parents, and managing my own financial affairs.
   [ ] I am seeking "minor consent" services. I will tell my doctor what services I want.

2. I understand my consent covers only those services identified. I understand that I can change my mind later on and decide I do not want health or mental health services at [*insert name of health services provider*]. I also understand that I can ask for new or additional minor consent services at any time.

3. I understand that [*insert name of health services provider*] is *required* to keep my health information protected but that in some cases, they may need or be required to share it by law. I understand that I can ask for more information about confidentiality and when my information may be shared.

Signature of Student:_____ Date:_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION
[*insert name of school health clinic or provider*]

Student/Patient Name:_____ Date of birth:_____ Grade:_____

[*Insert name of school based health provider or clinic]* keeps medical records confidential. However, at times we may want to collaborate with other agencies, providers and school staff to provide better health care to your child – for example, to assess your child's health needs, coordinate your child's care with school staff, provide treatment or referral, or evaluate the services provided. This may require disclosing some of your child's confidential medical information to others. In most cases, we need your permission to share this information. We will share the minimum amount of information necessary to accomplish these purposes.

1. Please initial one of the following two options:

[___] **I GIVE [*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*] PERMISSION** to share or disclose medical records and medical information about my child with the persons and agencies specified under (2) below for the purposes described above. This may include contact and appointment information, immunizations, history, diagnosis, treatment and mental health records (diagnosis, progress, and medication information). This release does NOT authorize [*Insert name of school based health provider or clinic*] to disclose information regarding HIV testing, treatment or status; drug or alcohol abuse, diagnosis or treatment; inpatient mental health services; psychotherapy notes; or minor consent[1] services.

[___] **I GIVE [*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*] PERMISSION** to share or disclose all medical records and information as described in the paragraph above with the persons and agencies specified under (2) below, **except** the following information:

_____

[*Insert name of school based provider or clinic*] and its staff must have a separate authorization from me to disclose the information I describe on this line.

2. **[*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*] MAY SHARE THIS INFORMATION** with the following persons and agencies:

[___] [*Insert Name of school*] professional health staff
[___] [*Insert Name of school*] Multidisciplinary team members
[___] Others: _____
(name or position of person or category of persons authorized to use or receive information)

[1] "*Minor consent" services are services that minors may obtain on their own behalf.*

NOTICES AND EXPLANATION OF RIGHTS:

1. I understand that [*Insert name of school based health provider or clinic*] may share or be required to share my child's health care information with certain persons or agencies for purposes of treatment, health care operations, and billing and payment, or as otherwise required by law, without having to ask my permission or needing a signed authorization.

2. I understand that I may change my mind and decide I do not want [*Insert name of school based health provider or clinic*] to disclose information as described above. This is called a revocation. I understand that I may revoke this authorization by writing to [*insert name and address of person to whom revocation should be directed*].

3. Once [*insert name of person to whom revocation should be directed*] receives my written notice of revocation, [*insert name of person to whom revocation should be directed*] will stop sharing information from that point on. I understand that revocation does not apply to the information [insert name of clinic] already released.

4. I understand that I have the right to refuse to sign this authorization. I understand that [*insert name of school based health provider or clinic*] may not deny my child treatment or eligibility for benefits just because I choose not to sign this authorization.

5. I understand that if [*insert name of school based health provider or clinic*] discloses information to a person or organization that is not legally required to keep it confidential, the information may be re-disclosed and no longer be protected.

6. I understand that I have a right to receive a copy of this signed authorization.

Signature of Parent/Guardian:_____

Print Name:_____ **Date:** _____

Describe Relationship to Patient:_____

THIS AUTHORIZATION IS VALID for one year from the date signed or until the following:
_____ (*specify expiration date or event)*

This form satisfies the requirements of HIPAA, 45 CFR section 164.508.

MINOR'S AUTHORIZATION TO RELEASE HEALTH INFORMATION
[*INSERT NAME OF SCHOOL HEALTH CLINIC OR PROVIDER*]

Student/Patient Name:_____ Date of birth:_____ Grade:_____

[*Insert name of school based health provider or clinic]* keeps medical records confidential. However, at times we may want to collaborate with other agencies, providers and school staff to provide better health care to you – for example, to assess your health needs, coordinate your care with school staff, provide treatment or referral, or evaluate the services provided. This may require disclosing some of your confidential medical information to others. In most cases, we need your permission to share this information. We will share the minimum amount of information necessary to accomplish these purposes.

1. Please initial one of the following:

[___] **I GIVE [*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*] PERMISSION** to share or disclose medical records and medical information related to care that I consented to for myself with the persons and agencies specified under (2) below for the purposes described above. This may include contact and appointment information; or information about immunizations; pregnancy; birth control; STD testing and treatment; or basic progress or diagnosis information about mental health counseling. **This release does NOT authorize** [*Insert name of school based health provider or clinic*] to disclose information regarding HIV testing, treatment or status; drug or alcohol abuse diagnosis or treatment; inpatient mental health services; details of mental health counseling; or psychotherapy notes.

[___] **I GIVE [*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*] PERMISSION** to share or disclose all medical records and information as described in the paragraph above with the persons and agencies specified under (2) below, **except** the following information:

_____

[*Insert name of school based health provider or clinic*] and its staff must have a separate authorization from me to disclose the information I describe on this line.

2. **[*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*] MAY SHARE** this information with the following persons and agencies:

[___] [*Insert Name of school*] professional health staff
[___] [*Insert Name of school*] Multidisciplinary team members
[___] Parents or Guardians (In some cases, [*Insert name of school based health provider or clinic*] cannot share information with your parents about health care you consented to without your permission. Please ask if you want more information about this law.)
[___] Others: _____
(Insert name or position of person or category of persons authorized to use or receive information)

NOTICES AND EXPLANATION OF RIGHTS:

1. I understand that [*Insert name of school based health provider or clinic*] may share or be required to share my child's health care information with certain persons or agencies for purposes of treatment, health care operations, and billing and payment, or as otherwise required by law, without having to ask my permission or needing a signed authorization.

2. I understand that I may change my mind and decide I do not want [*Insert name of school based health provider or clinic*] to disclose information as described above. This is called a revocation. I understand that I may revoke this authorization by writing to [*insert name and address of person to whom revocation should be directed*].

3. Once [*insert name of person to whom revocation should be directed*] receives my written notice of revocation, [*insert name of person to whom revocation should be directed*] will stop sharing information from that point on. I understand that revocation does not apply to the information [insert name of clinic] already released.

4. I understand that I have the right to refuse to sign this authorization. I understand that [*insert name of school based health provider or clinic*] may not deny my child treatment or eligibility for benefits just because I choose not to sign this authorization.

5. I understand that if [*insert name of school based health provider or clinic*] discloses information to a person or organization that is not legally required to keep it confidential, the information may be re-disclosed and no longer be protected.

6. I understand that I have a right to receive a copy of this signed authorization.

Signature of Student Patient:_____

Date: _____

THIS AUTHORIZATION IS VALID for one year or until the following:_____
(*specify expiration date or event)*

This form satisfies the requirements of HIPAA, 45 CFR section 164.508.

CONSENT TO RELEASE OF EDUCATION RECORDS TO [*INSERT NAME OF SCHOOL BASED HEALTH PROVIDER OR CLINIC*]

[*Insert name of school based health provider or clinic*] at times may need information contained in your child's school record in order to better assess your child's health needs, coordinate your child's care, provide treatment or referral, or evaluate the services provided. For example, the clinic staff may need to access your child's class schedule in order to arrange appointments or your contact information in order to consult with you. In addition, school staff may want to share otherwise protected information with the clinic staff so that they can make a referral or participate on a multidisciplinary health team. The clinic staff needs your permission to get and receive this information.

Please check one of the following:

[ ] **I GIVE [NAME OF SCHOOL] AND ITS STAFF PERMISSION** to share information from my child's education record, including contact information, attendance records, class schedule, transcript, discipline records, health and special education records, and testing results, with [*insert name of school based provider or clinic*] and its staff for the purposes described above.

[ ] **I GIVE PERMISSION TO SHARE ALL INFORMATION** from my child's education record as described in the paragraph above, except the following:

_____

If [*insert name of school based provider or clinic*] and its staff need the information I describe on this line, they must contact me for a separate consent.

THIS CONSENT IS VALID FOR ONE YEAR OR UNTIL the following:

_____

(Specify expiration date or event)

Student Name:_____ Date of birth:_____ Grade:_____

Parent/Guardian Name:_____

SIGNATURE:_____ **DATE**:_____

(Parent must sign if student is under 18 years old. Student must sign if age 18 or older. The term "parent" is defined in federal law and school district policy.)

This form meets the requirements of 34 CFR § 99.30 of the Family Educational Rights and Privacy Act.

COLORADO ASSOCIATION FOR
SCHOOL-BASED HEALTH CARE