Kim Stanger

Partner
208.383.3913
Boise
kcstanger@hollandhart.com

Idaho's New Parental Consent Law: FAQs

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Idaho's new parental consent law took effect July 1, 2024. Under the new law:

- "[A]n individual shall not furnish a health care service or solicit to furnish a health care service to a minor child without obtaining the prior consent of the minor child's parent."[1]
- "[N]o health care provider or governmental entity shall deny a minor child's parent access to health information that is [i]n such health care provider's or governmental entity's control…."[2]

"'Minor child' means an individual under eighteen (18) years of age but does not include an individual who is an emancipated minor."[3] Parents may sue healthcare providers and other individuals who violate the law.[4] For more information about the law, see our articles at New Limits on Minor Consents in Idaho, Blanket Consents Under Idaho's New Minor Consent Law, and Idaho's New Parental Access Law v. HIPAA. In the meantime, here are my answers and, in some cases, my best guesses in response to common questions I receive concerning the law.

1. To which healthcare services does the new law apply?

The law is extremely broad: it applies to any "health care service," which means "a service for the diagnosis, screening, examination, prevention, treatment, cure, care, or relief of any physical or mental health condition, illness, injury, defect, or disease."[5] As discussed below, the statute itself does **not** exempt certain services or conditions such as contraceptives, communicable diseases, or counseling.

2. Who are "parents" from whom consent must be obtained?

"'Parent' means a biological parent of a child, an adoptive parent of a child, or an individual who has been granted exclusive right and authority over the welfare of a child under state law."[6] The reference to those with "exclusive right and authority" is problematic. It would certainly include guardians appointed by the court, but likely would not include foster parents, relatives, temporary caregivers, or others who, until July 1, were able to consent for the care of a minor in the absence of a parent or court-appointed guardian pursuant to I.C. § 39-4504. Instead of relying on such persons, providers now must seek consent from a parent, which may result in unnecessary delay or denial of care that is urgent but that might not constitute a "medical emergency" under the statute.[7]

3. Must both parents consent?

No, the law only requires the "prior consent of the minor child's parent."[8] Note that "parent" is singular and, accordingly, a health care provider or other individual may appropriately rely on the consent of one parent. This is consistent with I.C. § 39-4504(1)(e), which affirms that "[a] parent"—not necessarily both parents—may consent to the care of a minor or other incompetent person. As a practical matter, if the parents disagree or a provider thinks one parent may object, the provider may want to avoid getting in the middle of the dispute and may decline to render care until the parents work it out, thereby avoiding the ire, threats, and potential disruption caused by the objecting parent. If, however, the provider believes the minor needs the care and the provider is willing to assume the risk, the provider most likely can render care based on the consent of one parent even if the other parent objects. Section 39-4504(3) states, "No health care provider who, in good faith, obtains consent from a person pursuant to [I.C. § 39-4504] shall be subject to civil liability therefor…."[9] In such cases, the provider will want to carefully document one parent's consent and the exigent circumstances that warranted the minor's care over the other parent's objection.

4. May parents delegate their authority to consent?

The statute does not expressly address such situations, but I think a parent can probably delegate their authority or appoint someone else to make decisions, e.g., a grandparent or temporary caregiver. Doing so would seem to be consistent with the new statute because it still honors the parent's authority to be make healthcare decisions, including the decision to delegate.[10] Allowing parental delegation would be consistent with I.C. § 39-4504(1)(f), which allows consent by "[t]he person named in a delegation of parental authority executed pursuant to [I.C. §] 15-5-104…." With that said, before a provider relies on such delegation, the provider will likely want to verify and document the delegation and the scope of such delegated authority with the parent. Also, problems or disputes may arise if one parent delegates authority over the objection of the other parent. Providers should be cautious when relying on any delegated authority: the more significant, risky, controversial, or expensive the care, the more the provider may want to obtain consent directly from a parent to avoid disputes or problems.

5. What if parents refuse care?

The right to consent to care generally includes the right to refuse care.[11] A provider may report parents for child neglect if they refuse to consent to "proper … medical or other care … necessary for [the child's well-being]…."[12] When in doubt, a provider may contact Child Protective Services (CPS), explain the situation, and ask if it is reportable, then document CPS's response. In extreme cases, Idaho allows a provider to seek an expedited court order authorizing emergent care.[13]

6. Who is required to obtain parental consent?

By its express terms, the law applies to any "individual" who solicits or furnishes a healthcare service;[14] it is not limited to licensed healthcare providers. The law allows a parent to sue any "individual, health care

provider, or governmental entity" who violates the statute.[15] "Health care provider" means:

> (i) A physician, health care practitioner, or other individual licensed, accredited, or certified to perform health care services or provide counseling consistent with state law, or any agent or third-party representative thereof; or
> (ii) A health care facility or its agent.[16]

On the other hand, "individual" is not defined: it apparently would include any person (whether or not a health care professional) who undertakes to render any kind of health service to a minor child, including relatives, friends, co-workers, teachers, babysitters, coaches, first responders, volunteers, and anyone else who may be trying to help a child with even minor concerns. Any such individuals may be sued by a disgruntled parent. As a practical matter, a parent likely would not suffer damages to make such a lawsuit worthwhile for minor situations, but the statute would still allow the parent to recover and may require the individual to incur attorneys' fees if the parent is simply looking to make a statement or harass the individual who tried to help the child. This is a disturbing potentiality that likely was not foreseen or intended by the legislature.

7. Does the new rule apply to labs, pathologists, radiologists, or others who may not have direct contact with the patient?

Unfortunately, the definitions of "health care provider" and "health care services" are broad enough to cover labs and other providers without a direct relationship with the minor: their services are likely "for the diagnosis, screening, examination, prevention, treatment, cure, care, or relief of any physical or mental health condition, illness, injury, defect, or disease."[17] Accordingly, the new law applies and such health care providers should obtain parental consent even if they do not have a direct treatment relationship. Presumably, such entities would work with the ordering provider to confirm that effective parental consent was obtained unless one of the statutory exceptions applies.

8. Are there exceptions to the consent requirements?

Yes, but they are very limited. The law does not apply if care is ordered by a court.[18] Also, the law does not apply and

> a health care provider may authorize or furnish a health care service without obtaining the informed consent of the minor child's parent, if:
> (a) A parent of the minor child has given blanket consent authorizing the health care provider to furnish the health care service; or
> (b) The health care provider reasonably determines that a medical emergency

exists and:

> (i) Furnishing the health care service is necessary in order to prevent death or imminent, irreparable physical injury to the minor child; or
> (ii) After a reasonably diligent effort, the health care provider cannot locate or contact a parent of the minor child and the minor child's life or health would be seriously endangered by further delay in the furnishing of health care services.[19]

Curiously, by the statute's express terms, these exceptions only apply to a "health care provider" who renders care; the exceptions do not extend to other non-provider "individuals" who may render some health service. That is, of course, another unfortunate defect in the statute.

9. Does the new law preempt other laws that allow minors to consent, *e.g.*, for contraceptives, STDs and other communicable diseases, mental healthcare, etc.?

Frankly, we do not know for certain whether the new statute preempts other conflicting Idaho laws, which leaves providers in a precarious situation when treating minors who, in the past, could consent for themselves under applicable law. The new law does not expressly address whether it preempts conflicting laws, but the Statement of Purpose that accompanied the law confirms "the Act is intended to supersede any current provisions of Idaho law that may otherwise conflict with the Act."[20] According to the Idaho legislature's Joint Rule 18, "statements of purpose [are not] intended for any use outside of the legislative process, including judicial review."[21] Nevertheless, Idaho courts often look to a law's Statement of Purpose when determining legislative intent and interpreting a statute; the courts have done so in numerous decisions that issued after Joint Rule 18.[22] The new law itself states that it "shall be construed in favor of a broad protection of parents' fundamental right to make decisions concerning the furnishing of health care services to minor children,"[23] which declaration appears consistent with Statement of Purpose that the law should preempt conflicting state laws. Given the potential for parental lawsuits and until we receive a court decision or other authoritative commentary to the contrary, the more cautious approach is to assume that the new parental rights statute preempts conflicting Idaho laws, including those allowing minors to consent to their own care or denying parental access to a minor's healthcare information.[24] Providers who choose to rely on a prior law that allows minors to consent to their own care may ultimately be proven right, but in the meantime they face the risk and cost of lawsuits with no guarantee of success. This leaves providers in an

untenable situation that needs to be resolved by the legislature or courts as soon as possible.

Whether the new law preempts contrary federal laws would depend on an analysis of the federal law, including but not limited to EMTALA, Title X programs offering family planning services, and substance use disorder programs.

10. What is a "blanket consent" and does it trump the need for informed consent?

Under the statute, "a health care provider may authorize or furnish a health care service **without obtaining the informed consent** of the minor child's parent, if … [a] parent of the minor child has given blanket consent authorizing the health care provider to furnish the health care service."[25] The statute does not define the meaning, requirements, or scope for valid blanket consents, but the concept appears to be that a parent can give broad consent for current or future care without the usual need to obtain specific informed consent. This is a significant change from established Idaho law that generally requires informed consent.[26] For a lengthy discussion of and my best guesses concerning blanket consents, see my article, Blanket Consents Under Idaho's New Minor Consent Law.

11. Must a separate blanket consent be obtained for each episode of care, annually, or otherwise?

We do not really know the scope of permissible blanket consents. A separate blanket consent is probably not required for each episode of care so long as the blanket consent obtained is sufficiently broad to cover the care actually rendered. With that said, providers should be cautious about situations in which a significant amount of time has passed, circumstances have changed, or the care is beyond that which the consenting parent may have anticipated. When in doubt, providers should discuss the scope of their care with the parent to ensure the parent and provider are on the same page as to the scope, duration, and effect of the consent provided. Again, it would be safer to obtain specific informed consent in cases of risky, controversial, or expensive care. See my article, Blanket Consents Under Idaho's New Minor Consent Law, for further discussion.

12. Must parental consent be written or may it be verbal?

The new law does not require written consent, so I.C. § 39-4506 should apply:

> It is not essential to the validity of any consent for the furnishing of health care services that the consent be in writing or any other specific form of expression; provided however, when the giving of such consent is recited or documented in writing and expressly authorizes the health care services to be furnished, and when such writing or form has been

> executed or initialed by a person competent to give such consent for himself or another, such written consent, in the absence of convincing proof that it was secured maliciously or by fraud, is presumed to be valid for the furnishing of such health care services, and the advice and disclosures of the attending licensed independent practitioner or dentist, as well as the level of informed awareness of the giver of such consent, shall be presumed to be sufficient.

Thus, written signed informed consent or signed blanket consent is preferable, especially for significant, risky, controversial, or expensive care. If verbal consent is obtained, the provider should carefully document the consent in the medical record and consider following up with the parent to obtain a signed, written consent or acknowledgment of consent as soon as practicable thereafter.

13. To whom does the parental access rule apply?

Unlike the consent provisions, the statute allowing parental access to the minor's health information only applies to healthcare providers and governmental entities.[27]

14. What information may parents access?

A parent has a right to access any health information that is "[i]n such health care provider's or governmental entity's control; and [r]equested by the minor child's parent."[28]

> "Health information" means information or data, collected or recorded in any form or medium, and personal facts of information about events or relationships that relates to:
> (i) The past, present, or future physical, mental, or behavioral health or condition of an individual or member of the individual's family;
> (ii) The provision of health care services to an individual; or
> (iii) Payment for the provision of health care services to an individual.[29]

Thus, parents are not only entitled to access records; they are entitled to access facts and other information concerning the treatment even if not recorded.

15. Are parents entitled to access information created or relating to

care rendered prior to July 1, 2024, when the new law took effect?

Apparently, yes. The statute does not contain any exception for information created or care rendered before the new law took effect even if the minor had authority to consent for his/her own care at the time or the information was created under a promise or assumption of confidentiality. Instead, the statute applies to any information, including "[t]he past, present, or future physical, mental, or behavioral health or condition of an individual or member of the individual's family [or] provision of health care services to an individual…."[30] The new law creates a dilemma for providers: do they respect the parental rights affirmed under the new law or do they honor the duty of confidentiality they owed to the minor when the care was rendered? If they grant parental access under the new law, the minor may assert a HIPAA or common law claim for a privacy violation. If they deny parental access, the parent may sue under the new law. It is not entirely clear how a court would ultimately rule. On the whole, it is likely safer to assume the new law applies to pre-existing records or information, but this is another issue that the legislature and courts should resolve as soon as possible and without penalizing providers in the meantime.

16. Are there exceptions to the parental access requirements?

Yes, but they are very limited. Parents do not have a right to access information if:

> (a) Parent's access to the requested health information is prohibited by a court order; or
> (b) The parent is a subject of an investigation related to a crime committed against the child, and a law enforcement officer requests that the information not be released to the parent.[31]

Note that this exception is much narrower than the abuse or endangerment exceptions allowed by HIPAA.

17. Does HIPAA limit a parent's access to information?

HIPAA generally defers to state law when it comes to parental access;[32] nevertheless, there are fairly good arguments that HIPAA may limit disclosure to parents in the case of abuse or endangerment situations. For more information on this issue, see my article, Idaho's New Parental Access Law v. HIPAA.

18. What happens if an Idaho minor receives care in another state (which state allows a minor to consent), or a minor from another state receives care in Idaho?

These are difficult situations involving choice of law principles that are not easily applied. Providers should consult with their own attorney to analyze the facts of each case. As a general matter, however, Idaho providers

should assume they must comply with the Idaho consent laws if they render care in Idaho regardless of the home state of the patient or their parents.

Conclusion. Unfortunately, the new parental consent law raises many unanswerable questions and imposes many practical problems for providers and their minor patients. Hopefully, the legislature and courts will fix problems in the statute promptly without unfairly penalizing providers or harming minors in the meantime. Until then, providers should carefully review and, as necessary, modify their polices, practices, and insurance coverage.

[1] I.C. § 32-1015(3).

[2] I.C. § 32-1015(5).

[3] I.C. § 32-1015(1)(e).

[4] I.C. § 32-1015(12).

[5] I.C. § 32-1015(1)(c).

[6] I.C. § 32-1015(1)(f).

[7] *See* I.C. § 32-1015(4)(b).

[8] I.C. § 32-1015(3).

[9] I.C. § 39-4504(3).

[10] *See, e.g.*, I.C. § 32-1015(7).

[11] I.C. § 39-4501, definition of “consent.”

[12] I.C. § 16-1602(31) and § 16-1605.

[13] I.C. § 16-1627.

[14] I.C. § 32-1015(3).

[15] I.C. § 32-1015(12(a).

[16] I.C. § 32-1015(1)(b).

[17] I.C. § 32-1015(1)(c).

[18] I.C. § 32-1015(3).

[19] I.C. § 32-1015(4).

[20] Statement of Purpose for SB1329, available at https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2024/legislation/S1329SOP.pdf.

[21] Joint Senate and House Rules 18, available at

https://legislature.idaho.gov/statutesrules/jointrules/.

[22] *See, e.g., State v. Barr,* 2024 Ida. LEXIS 53 (2024); *White v. Idaho Trans. Dept*., ___ Idaho ___, 549 P.3d 1077 (2024); *Nelson v. City of Pocatello*, 170 Idaho 160, 508 P.3d 1234 (2023); *Durst v. Idaho Comm'n for Reapportionment,* 169 Idaho 863, 505 P.3d 324 (2022); *Pentico v. Idaho Comm'n for Reapportionment*, 169 Idaho 840, 504 P.3d 376 (2022); *Reclaim Idaho v. Denney*, 169 Idaho 406, 497 P.3d 160 (2021); *Bennett v. Bank of E. Or*., 167 Idaho 481, 472 P.3d 1125 (2020); *Goodrick v. Field (In re Order Certifying Question to Idaho Supreme Court)*, 167 Idaho 280, 472 P.3d 1125 (2020); *Woolley v. Bridge St., Inc*., 166 Idaho 559, 462 P.3d 87 (2020); *State v. Osborn*, 165 Idaho 627, 449 P.3d 419 (2019); *State v. Lantis*, 165 Idaho 427, 447 P.3d 875 (2019); *Hardy v. Phelps*, 165 Idaho 137, 443 P.3d 151 (2019); *State v. Kinney*, 163 Idaho 663, 417 P.3d 989 (2018); *State v. Passons,* 2017 Ida. App. LEXIS 61 (App. 2018); *Searcy v. Idaho State Bd. of Corr.*, 160 Idaho 546, 376 P.3d 750 (2016); *N. Snake Ground Water Dist. v. Idaho Dep't of Water Res*., 160 Idaho 518, 376 P.3d 750 (2016); *Farmers Nat'l Bank v. Green River Dairy, LLC*, 155 Idaho 853, 860, 318 P.3d 622, 629 at n.4 (2014), citing *KGF Development, LLC v. City of Ketchum*, 149 Idaho 524, 236 P.3d 1284 (2010) and *Stuart v. State*, 149 Idaho 35, 232 P.3d 813 (2010) ("Although the statement of purpose that accompanies a piece of legislation may not always be the best source for determining legislative intent, this Court has often looked to the statement of purpose for guidance."); *see also* B. Davis, K. Kelly and K. Ford, *Use of Legislative History: Willow Witching for Legislative Intent*, 43 Idaho L. Rev. 585, 594 (2007) ("Idaho courts cite more frequently to statements of purpose, as an expression of legislative intent, than to any other single type of legislative history material."); S. Adams, *Listing Cannons of Construction* at p.2, available at https://isb.idaho.gov/wp-content/uploads/canons_w_commentary.pdf ("The legislative purpose in enacting a statute is also a factor to be considered in statutory construction."); K. Ford, *Idaho Legislative History*, available at https://www.uidaho.edu/-/media/UIdaho-Responsive/Files/law/library/legal-research/guides/idaho-legislative-history.pdf ("Idaho appellate courts cite the Statement of Purpose as an aid to interpretation.").

[23] I.C. § 32-1015(7).

[24] This situation also presents a conundrum involving two different canons of statutory construction: (1) if two statutes are irreconcilable, the later in date usually controls; and (2) if two statutes address the same subject, the more specific statute usually controls over the general statute. As one author wrote, "The difficulty with these two rules is when [as here] there is a later, general statute. In such circumstances, which of these rules of construction governs? … There is not necessarily a clear answer to these questions. In such circumstances, the best proposed interpretation will likely be the most reasonable interpretation." (S. Adams, *Listing Cannons of Construction* at pp.9-10, available at https://isb.idaho.gov/wp-content/uploads/canons_w_commentary.pdf).

[25] I.C. § 32-1015(4), emphasis added.

[26] I.C. §39-4506.

[27] I.C. § 32-1015(5).

[28] I.C. § 32-1015(5).

[29] I.C. § 32-1015(1)(d).

[30] I.C. § 32-1015(1)(d).

[31] I.C. § 32-1015(6).

[32] *See* 42 C.F.R. § 164.502(g)(3)(ii).
