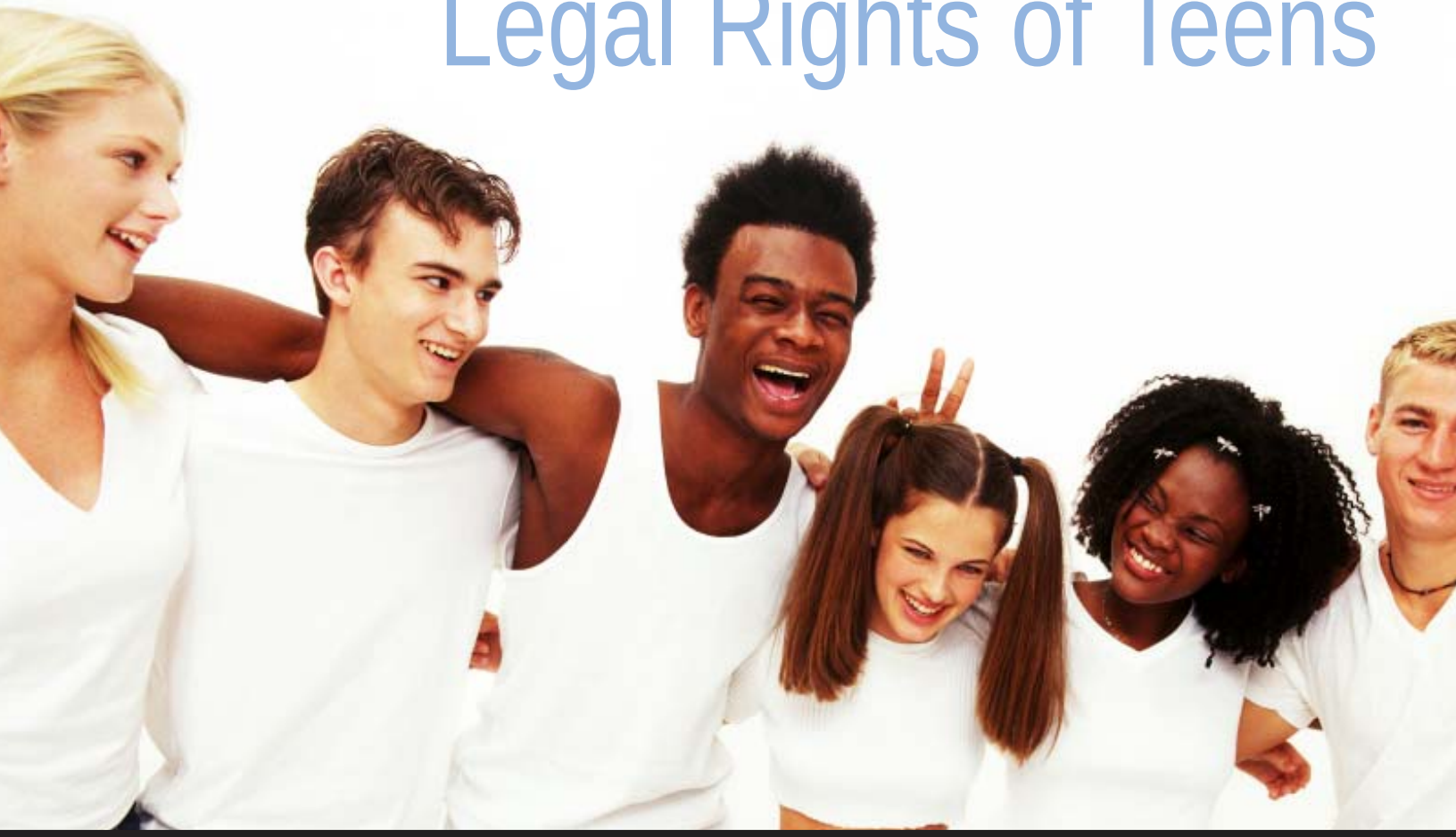
Adolescent Health Care

Legal Rights of Teens



Center for Children's Advocacy

Medical-Legal Partnership Project

Preface

This book is intended as practical assistance for health care providers, health care policy makers, and attorneys representing adolescents. It covers the explicit references to Connecticut and Federal law regarding confidentiality in adolescent medical care. Some references to pertinent ethical guidelines have been included as a reference to generally accepted medical principles guiding adolescent medical care and treatment.

The idea to create this book came from numerous requests and suggestions from local health care organizations, and arose in the larger context of the Hartford Action Plan on Infant Health's mission to work with Breaking the Cycle, Hartford's teen pregnancy prevention campaign. The book is intended to highlight basic confidentiality issues that arise when treating adolescents. For more informationabout the Hartford Action Plan and Breaking the Cycle, please call (860) 236-4872.

This book is intended as a reference only. It should not be interpreted as legal advice in an individual case, but only as a general resource guide to assist the health care provider or attorney in treating and counseling the adolescent patient. Please note that the majority of statutes referred to in text are Connecticut based, and do not necessarily reflect the prevailing law in other jurisdictions. Practitioners from other jurisdictions are encouraged to consult local statues/regulations that govern adolescent confidentiality matters.

This book reflects the law as of January 2008. Please check the Center for Children's Advocacy website at *www.kidscounsel.org* for statutorychanges that may have occurred since publication.

Adolescent Health Care: The Legal Rights of Teens

Third Edition

Since our original publication of *Adolescent Health Care: The Legal Rights of Teens* in September 2000, much has changed regarding a teenager's legal rights in the health care setting and the issues surrounding an adolescent's right to confidential health care treatment.

The advent and proliferation of HIPAA, as well as refinements to Connecticut and federal law regarding privacy, birth control (Plan B), sexual assault (i.e. statutory rape) and mandatory reporting – and the ever-changing federal landscape regarding abortion rights – have necessitated a full revision of this book.

While we believe that we have captured the most up-to date-laws, regulations and policies surrounding adolescent health care, the landscape has a way of changing from the time of writing to the time of publication. As a result, we urge readers, practitioners, and attorneys to use this book *only* as a reference point, and to seek counsel from administrators, risk management personnel, and counsel before acting in this critically important area of teenage legal rights in the health care setting.

We welcome comments and critique on the content of this book. Practitioners are invited to provide feedback to the authors at the Center for Children's Advocacy, as well as to frequently check the latest relevant legal updates on our website at *www.kidscounsel.org*.

The Center's Medical-Legal Partnership Project (MLPP) staff is available for trainings, forums, and symposia on issues surrounding adolescent healthcare and the legal rights of teens. Since the publication of the first edition of this book, MLPP attorneys and law student interns have given over one hundred presentations on adolescent health care and confidentiality issues to attending physicians, pediatric, family medicine and internal medicine residents, mid-level practitioners, nurses, social workers, hospital administrators and attorneys. If your organization would like to schedule a training or forum with MLPP staff, please contact the MLPP project director at (860) 714-1412, or call the Center for Children's Advocacy at (860) 570-5327.

Acknowledgements and Contact Information

Acknowledgements

This book was written by Center for Children's Advocacy Attorneys Jay Sicklick, Deputy Director and Director of the Medical-Legal Partnership Project; and Martha Stone, Executive Director.

The Center is a private, non-profit organization dedicated to protecting and promoting the legal rights of poor children. CCA staff provide legal representation to children falling through the cracks of the child welfare, health, mental health, education and juvenile justice systems.

The Center's Medical-Legal Partnership Project is an interdisciplinary collaboration with the Connecticut Children's Medical Center, Saint Francis Hospital and Medical Center, Charter Oak Health Center, Community Health Services, The Hospital of Central Connecticut, and community pediatricians. This collaborative partnership was formed to provide improvement in children's health through legal advocacy and policy reform.

The MLPP employs a preventive, multi-disciplinary approach to improving child health by ensuring that families' basic needs are met – safe housing, adequate income and benefits support, disability advocacy, access to health care, freedom from violence and abuse, and appropriate educational services.

For more information about the Center for Children's Advocacy and the Medical-Legal Partnership Project, please visit *www.kidscounsel.org*.

The authors wish to acknowledge the assistance in the preparation of this manual of former CCA staff attorneys Gladys I. Nieves and Keely Magyar, and legal interns Gwen Goodman, Michelle Fica, and Alexis Williams.

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Contact Information

Healthcare providers who have questions about this material or seek additional information about adolescent confidentiality should contact:

Center for Children's Advocacy
Medical-Legal Partnership Project (MLPP)

MLPP office at Connecticut Children's Medical Center
860-545-8581

MLPP office at Saint Francis Hospital
860-714-1412

Center for Children's Advocacy
65 Elizabeth Street, Hartford, CT 06105
860-570-5327

www.kidscounsel.org

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Definitions

Consent is defined in the context of privileged communications as "written consent" by the patient or his/her authorized representative. *See* e.g., Conn. Gen. Stat. § 52-146d(3) (psychiatrist-patient privilege).

Emancipated Minor is one who is 16 or 17 years of age and has been declared "emancipated" by the court because 1) the minor is married; 2) the minor actively serves in the U.S. Armed Forces; 3) the minor willingly lives away from home and manages his or her own finances with or without parental consent; or 4) the court determines "for good cause" that emancipation is in the "best interest" of the minor. *See* Conn. Gen Stat.§ 46b-150.

HIPAA is the Health Insurance Portability and Accountability Act, first passed by Congress in 1996. While HIPAA was originally intended to simplify rules regarding the portability of insurance coverage for employees leaving their places of employment, it has transformed into a complicated statutory and regulatory structure that dictates much of how health information is protected due to privacy and confidentiality concerns. *See www.hhs.gov/ocr/hipaa.*

Informed Consent is the medical doctrine whereby medical providers (physicians, hospitals, etc) inform patients of the risks and benefits of alternative approaches to treatment and the risks and possible consequences resulting from those approaches. After such an explanation, the medical provider obtains a signed consent from the patient who acknowledges receipt of the information and an understanding of the risks and benefits of the procedure or treatment. The root premise in the doctrine of informed consent is that "every human being of adult years and sound mind has a right to determine what shall be done with his own body ..."[1]

Living Will is a legal document that states a person's wishes regarding any aspect of health care, including withholding or withdrawal of life-support systems. It is a sub-category of "advanced directives," which are written instructions, such as a living will or durable power of attorney, which are recognized under Connecticut law to express a person's wishes as to health care if the person is unable to communicate treatment decisions. It is a process regulated by statute in Connecticut. *See* Conn. Gen. Stats. §§ 19a-575 *et seq.*

Mandated Reporter is defined as a health care professional/provider (e.g. physician, surgeon, registered nurse practioner, registered nurse, etc.) who, in his/her professional capacity, has reasonable cause to suspect or believe that a child has been abused/neglected or is at imminent risk of serious harm, shall report such abuse/neglect or risk of imminent serious harm to the Department of Children and Families or the police. *See* Conn. Gen. Stat. §§ 17a-101, 17a-101a. A mandatory reporter must report suspected abuse, neglect or risk of imminent serious harm if it is discovered in the ordinary course of such person's employment or profession.

Minor is defined for these purposes as anyone under 18 years of age, except as otherwise noted. *See* Conn. Gen. Stats. § 1-1d.

Definitions

Parental Consent is defined for these purposes as the consent of a parent or legal guardian. *See* Conn. Gen. Stat. § 45a-604. Only one parent need give "parental consent."

Privileged Communication is defined as any confidential oral or written communication and record relating to the diagnosis and treatment of a person, between such person and a treatment provider, or between a member of such person's family and a treatment provider.

Sexual Assault in the Second Degree where an actor engages in sexual intercourse with another person and the other person is thirteen years of age or older but under sixteen years of age, and the actor is more than **three** years older than such person. *See* Conn. Gen. Stat. § 53a-71, revised by Public Act No. 07-143, § 1.

Sexual Assault in the Fourth Degree when a person (a) intentionally subjects a person under thirteen years old and more than two years younger to sexual contact, or (b) intentionally subjects a person who is older than thirteen years old but younger than fifteen years old, to sexual contact and the person is more than three years older. Previously, sexual assault in the fourth degree only required that the person subjected to sexual contact be less than fifteen years old, regardless of the age difference. *See* Conn. Gen. Stat. § 53-73a, revised by Public Act No. 07-143, § 2.

Sexually Transmitted Disease is defined as a venereal disease. *See* Conn. Gen. Stat. § 19a-216. A venereal disease is traditionally defined as any of several contagious diseases, such as syphillis, gonorrhea, chlamydial infections, chancroid, or genital warts, that is contracted through sexual intercourse.

Statutory Rape is defined by statute in Connecticut, and consists of various separate criminal offenses classified under the "sexual assault" category. The offenses are:

- *Sexual Assault in the First Degree* when a person engages in sexual intercourse with another person and the person is under thirteen years of age and the "actor" is more than *two* years older than the person. See Conn. Gen. Stat. §53a-70. *See* also Conn. Gen. Stat. § 53a-65 for definitions of "sexual intercourse" and "actor";

- *Sexual Assault in the Second Degree* when an actor engages in sexual intercourse with another person and the other person is thirteen years of age or older but under sixteen years of age, and the actor is more than *three* years older than such person. *See* Conn. Gen. Stat. § 53a-71, revised by Public Act No. 07-143, § 1.

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[1] *Scholoendorff v. The Society of New York Hospital*, 211 N.Y. 125, 129-30 (1914) (Cardozo, J.)

Drug and Alcohol Treatment

Can a minor give consent for alcohol or drug treatment or rehabilitation?

Yes, a minor does not need parental consent to receive treatment or rehabilitation for drug or alcohol dependency.[2]

Who is liable for the costs and expenses?

Under Connecticut statutes, the minor is liable.[3]

Can a parent be told his/her child is receiving such treatment?

No, a parent cannot be told without the minor's consent.[4]

Must a parent/guardian be notified if a drug test/toxicology screen is done (e.g. as part of a routine physical exam or as part of a follow-up exam for an illness)?

In Connecticut, the law is silent with respect to a physician's duty to report to a parent the result of a drug test taken as part of a routine comprehensive examination. Knowing this, physicians carry with them an ethical duty to promote the autonomy of minor patients and thus, should treat the confidentiality of a minor as they would any adult. However, according to the American Medical Association guidelines,[5] confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment and/or when such breach is necessary to avoid serious harm to the minor patient.

What is the difference between Connecticut law and federal law regarding a minor who seeks drug or alcohol treatment?

In the case of a minor seeking drug treatment with a licensed substance abuse counselor (versus routine drug testing), however, Connecticut law falls in line with the federal Public Health Services Act (PHSA), which specifically restricts access to drug treatment records without the patient's consent, even a minor patient.[6] The PHSA allows for disclosure to a parent when there is a serious threat to the incompetent minor's life or physical well-being and it is determined that this threat can be diminished by disclosure to the parents. Please note the aforementioned does not compel disclosure, it simply exempts physicians from the federal requirement of obtaining written consent.

When must a physician abide by the PHSA versus state law?

Federal law only applies to providers and/or facilities that are "federally assisted". In general, if a provider or facility is funded, in whole or in part, by the federal government, they are federally assisted and must abide by federal law. However, in the case of drug treatment records, PHSA also requires the provider and/or facility to hold itself out as providing drug abuse diagnosis, treatment, or referral.[7] If these requirements are met, the physician and/or facility must abide by both the PHSA, as well as state law. If not, only state law applies.

Drug and Alcohol Treatment

What is the liability for conducting a drug or alcohol screening without the minor's permission?

Overall, Connecticut is silent with respect to the disclosure of a minor's routine drug test results, however, drug tests obtained in the course of drug treatment are protected by both federal and state law and these results must be kept confidential, unless exceptions otherwise allowed via applicable federal and/or state law. Medical providers should be aware that conducting a drug test on a minor patient without prior permission might be an infringement of the patient's right to privacy and might constitute a battery.

May a minor give consent for participation in a smoking cessation program?

This type of treatment is not defined as confidentially protected under Connecticut law. It is arguable, however, that, given the confidentiality afforded to minors who seek treatment for drug and alcohol addiction, the minor's privacy and confidentiality are also protected for those who seek smoking cessation treatment under the theory that nicotine (or tobacco) is an addictive substance. Federal confidentiality laws provide that drug abuse is "the use of psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well being of the user."[8]

Would a minor who enrolls in a smoking cessation program be entitled to confidentiality?

While this is an open question, a broad reading of the protections afforded to minors seeking drug and alcohol treatment, in conjunction with the federal regulations, indicates that a minor is probably entitled to confidentiality in this instance. Certainly, a provider's ethical obligation would be to grant a minor's confidential request for such treatment.

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[2] Conn. Gen. Stat. §17a-688(d).
[3] *Id.*
[4] *Id.*
[6] American Medical Association, E-5.055 *Confidential Care for Minors*
[6] *See* Conn. Gen. Stat. § 17a-688d.
[7] 42 CFR 2.11; 42 CFR 2.12 Youth Law News, Federal Privacy Protection for Substance Abuse Treatment Records: Protecting Adolescents, by Rebecca Gudeman.
[8] 42 C.F.R. §2.11.

Testing and Treatment of HIV and AIDS

Must minors seek parental consent to receive an HIV/AIDS test?

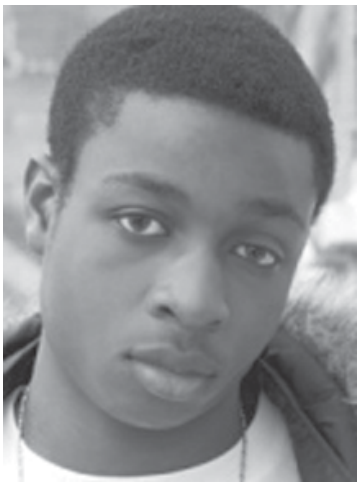
No, parental consent is not a prerequisite to the testing of a minor for HIV/AIDS.[9]

Who receives the lab report after testing?

The lab results must be sent directly to the person who orders the HIV/AIDS test.[10]

What are the responsibilities of the health care provider upon communicating HIV/AIDS test results to minors?

The provider must work toward the goal of involving the minor's parents or legal guardian in the decision to seek and in the ongoing provision of medical treatment[11], and the provider must counsel the minor about the need to notify his/her partners and if necessary, provide assistance in notifying partners at the time of communicating the test results.[12]



Must the physician warn or inform a known partner of a minor who tests positive for HIV/AIDS?

A physician may warn or inform a known partner if both the partner and the "protected individual" (the minor who tests positive) are under the physician's care and the physician reasonably believes there is a significant risk of transmission to the partner, the physician has counseled the protected individual and he or she reasonably believes the protected individual will not inform the partner, and the physician informs the protected individual of his or her intent to inform the partner.[13]

What is the Department of Public Health's duty to warn sexual partners of persons infected with HIV/AIDS?

A public health official may inform or warn partners of an individual that they may have been exposed to HIV under the following conditions:

1) The public health official reasonably believes there is a significant risk of transmission to the partner;

2) the public health official has counseled the protected individual regarding the need to notify the partner and the public health officer reasonably believes the protected individual will not inform the partner;

3) the public health official has informed the protected individual of such officer's intent to make such disclosure. The public health official may also warn or inform a partner at the request of a protected individual.[14]

Testing and Treatment of HIV and AIDS

Must the physician inform parents or a legal guardian prior to giving care and treatment for HIV/AIDS to a minor?

A physician may examine and treat a minor with HIV/AIDS without parental consent only if the physician determines that notification to the parents or guardian of the minor will result in denial of such treatment or that the minor will not seek or pursue treatment as a result of the notification.[15]

May the parents of a minor be billed for consultation, examination, and treatment of a minor with HIV/AIDS?

The treatment, as well as billing for services, is confidential and must not be divulged to a minor's parents or legal guardian. The physician may consult with the minor at a later time regarding the sending of a bill.[16] If the minor consents, the bill may be sent to the parents. As a result, a minor is personally liable for all costs and expenses resulting from HIV/AIDS treatment.[17]

Can a physician tell the parents after treatment has started?

No. The examination and treatment shall remain confidential.[18]

[9] Conn. Gen. Stat. §19a-582(a).
[10] *Id.*
[11] *Id.* at (d)(5).
[12] *Id.* at (d)(6).
[13] Conn. Gen. Stat. §19a-584(b).
[14] Conn. Gen. Stat. § 19a-584(a).
[15] Conn. Gen. Stat. §19a-592.
[16] *Id.*
[17] Conn. Gen. Stat. §19a-592(b).
[18] Conn. Gen. Stat. §19a-584.

Medical or Surgical Treatment

Must a hospital/health care provider obtain the informed consent of a parent/legal guardian before performing a medical or surgical procedure/treatment?

Although there is no statute directly governing this question, traditionally, under common law, parental consent is necessary for medical or surgical treatment that requires informed consent, except in cases where an explicit statutory exception exists, such as abortion, HIV/AIDS, STD testing and treatment, treatment of drug or alcohol abuse, hospitalization for mental disorder, outpatient mental health treatment (six visits), or if the minor is emancipated. The only other exception to this rule is during an emergency when it is either impractical to obtain parental consent or any delay would unduly endanger the patient's life. In these situations, permission by the parents/legal guardian for medical or surgical care is implied by law, since, assuming that the parents had known of the situation, they would have authorized the medical or surgical care. However, the AMA Code of Ethics (AMA Code) indicates that physicians should permit a "competent minor" to consent to medical care without parental notification or consent.[19]

This creates a tension in the law. By definition, a minor does not have the legal capacity to provide consent for treatments/procedures that require informed consent. The AMA Code implies that a "competent minor" may give such consent. This remains an unresolved issue under Connecticut law. The general rule, however, is that anyone under the age of majority (eighteen in Connecticut) does not possess the legal capacity to consent to a procedure that requires informed consent.

Is informed consent from a parent/legal guardian required prior to routine or non-emergent examination of a minor?

Connecticut law does not require informed consent for non-emergent or routine medical care for minors other than to mandate informed consent in general for "any procedure or treatment which ... is appropriate."[20] Note that the AMA Code recommends that physicians should encourage minors to consult with their parents and involve them in the decision-making process. It further indicates that where the law permits, a "competent minor" may consent to medical care without parental notification and consent.[21] As noted above, minors in Connecticut do not have the legal capacity to provide informed consent for procedures that ordinarily require informed consent. In addition, the AMA Code provides that physicians are charged with the responsibility of evaluating the "competence" of minors when dealing with these self-determination issues.[22] The AMA Code further provides, however, that a physician is ethically justified in disclosing a confidence when the physician believes that, without parental involvement, the minor will face serious health consequences, and the parents will be helpful and understanding. In the event of such a disclosure, the physician must discuss the breach of confidentiality with the minor prior to the disclosure.[23]

The American Academy of Pediatrics (AAP), in policy statements issued in 1989 and 1995, echoed the AMA's Code in that it recommended that adolescents should be provided with confidential examinations and counseling apart from their parents.[24]

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[19] *See* AMA Current Opinions of the Council on Ethical and Judicial Affairs E-5.055 Confidential Care for Minors. The AMA Code of Ethics may be accessed at *www.ama-assn.org/ama/pub/category/8355.html*. The entire Code of Ethics may be viewed at *www.ama-assn.org/ama/pub/category/8288.html.*

[20] Public Health Code, §19-13-D3(d)(8). The requirement is that each hospital must assure that the bylaws or rules or regulations of the medical staff include the requirement that, except in emergency situations, responsible physicians shall obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate and provide evidence of a form signed by the patient in the hospital record. *Id.*

[21] *See* footnote 14.

[22] *Id.*

[23] *Id.*

[24] *See* American Academy of Pediatrics Policy Statements: Confidentiality in Adolescent Health Care (RE9151), and Informed Consent, Parental Permission, and Assent in Pedicatric Practice (RE9510). *See* 95 Pediatrics 2 (Feb. 1995) at 314.

Medical or Surgical Treatment

Are hospitals/clinics required to obtain informed consent from a parent/legal guardian when a minor requires a procedure that requires informed consent but involves a protected confidential area, such as reproductive health care (e.g. epidural anesthesia, amniocentesis)?

While this is an unsettled area of the law, it is probable that the general rule that a parent/legal guardian must provide informed consent for procedures/surgical matters does not apply when the issue involves a protected confidential right of treatment, such as in the reproductive health care arena. While there is no statute or regulation that supports this tenet, the minor's constitutional right to reproductive freedom and confidentiality in the protected areas of reproductive rights, birth control, etc. provides legal support to the proposition that the minor possesses the legal capacity to provide informed consent without parental permission. The reality of risk management and liability issues, however, often intrude in this complex area of health care delivery, and hospitals/clinics often require parental consent in areas where the law suggests otherwise. *See Reproductive Health Care*, page 14 of this book.

May a legal guardian consent to medical or surgical treatment?

Yes.[26]

Is a grandparent, aunt, or other kinship caretaker automatically authorized to provide informed consent on behalf of minor relatives?

Absent an order from a court of appropriate jurisdiction (e.g. Probate Court in Connecticut) that provides legal status to the kinship caretaker (legal guardianship, legal custody, etc.), a kinship caretaker does not possess the legal status to provide informed consent for his/her relative. In the case that informed consent is mandated, the provider must obtain consent from the legally responsible caretaker (parent or legal guardian/custodian, or the Department of Children and Families) absent an emergency (see footnote 21).[27]

In addition, a "letter" from a parent or legal guardian does not convey legal status for healthcare decision making to a kinship caregiver, relative or friend, absent a court order from the Probate or Superior Court.

May a minor parent provide legally binding informed consent to her child when the child must undergo a procedure/treatment that requires the informed consent of a parent or legal guardian?

This is another one of the "gray areas" of the law which remains unsettled. By definition, a parent has the legal capacity to provide consent, both routine and "informed," for all medical care provided to his or her child. Thus, a minor who gives birth to a child requiring emergent surgery after birth would appear to have the legal capacity to provide the informed consent for her child's surgery. Ironically, however, if the minor-parent required surgery/treatment for a condition *unrelated to her pregnancy/delivery* after giving birth (e.g. she suffers a leg fracture walking out of the hospital), the present state of the law would require the hospital to obtain consent from the minor-parent's parent or legal guardian prior to performing surgery to repair the fracture. Such bright lines can be complicated by the infusion of child welfare officials or relative caregivers who take legal steps seeking custody of the baby upon delivery. Absent a court order, or 96 hour hold (placed by the Department of Children and Families or the hospital), the minor-parent should be afforded all legal rights and responsibilities of parenthood upon the delivery of her child.

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[25] *Id.* Examples in the AAP policy statement are - for school aged children: provision of psychotropic medication to control attention deficit disorder in a third grader; surgical repair of a malformed ear in a 12 year old. For adolescents and young adults: performance of a pelvic exam in a 16 year old, proposed long-term oral antibiotics administration for severe acne in a 15 year old.

[26] Conn. Gen. Stat. §45a-604.

[27] To date, only one state has enacted legislation empowering kinship caregivers who have not obtained court-sanctioned guardianship/custody providing the caretaker authority to consent to medical treatment of minors. In 1999, Delaware enacted 13 Del. C §708, Affidavit of Establishment of Power to Consent to Medical Treatment of Minors, authorizing caretaker relatives to consent or refuse medical treatment of a minor pendant upon presentation of an affidavit authorizing such treatment, signed by parents or legal guardians of the child.

Mental Health Treatment: Outpatient

Can a minor receive initial mental health treatment without parental consent?

A psychiatrist, psychologist, certified social worker, or licensed marital and family therapist can provide mental health treatment without parental consent or notification if:

- the consent requirement would cause the minor to reject treatment;
- the treatment is clinically indicated;
- the failure to receive the treatment would be seriously detrimental to the minor's well-being;
- the minor knowingly and voluntarily sought such treatment; and
- the provider deems the minor mature enough to participate in treatment productively.[28]

If the minor child can receive the initial treatment without parental consent, can the parent be notified of later treatments?

The minor can receive six sessions, after which time the provider must notify the parent and secure parental consent unless the provider determines that notification or consent would be seriously detrimental to the minor's well being.[29] After every sixth session, a reevaluation must take place.

Does the minor's consent need to be in writing?

Yes, the minor must sign a consent form regarding these issues.[30]

If a minor is liable for costs and expenses and doesn't pay, what happens?

The consequences of the unpaid costs and expenses remain the reponsibility of the minor. An uninformed parent is not liable for the treatment costs incurred.[31]

[28] Conn. Gen. Stat. §19(a)-14c(b).
[29] Conn. Gen. Stat. §19(a)-14c(c).
[30] Conn. Gen. Stat. §19(a)-14c(b).
[31] Conn. Gen. Stat. §19(a)-14c(d).

Mental Health Treatment: Inpatient

Can a minor be hospitalized for inpatient mental health treatment without his/her parent's consent?

A minor fourteen or fifteen years of age may be admitted to a hospital for the diagnosis or treatment of a mental health disorder if the minor provides written consent. Within five days of admission, however, the parents (or nearest relative) must be notified.[32]

What if the minor is sixteen years old?

For the purposes of inpatient mental health treatment, a "minor" or "child" is defined as any person less than sixteen years of age.[33] A child sixteen years of age or older is considered an adult "voluntary patient."[34]

What happens if a parent objects to the hospitalization?

If a parent requests in writing the release of a child who voluntarily committed himself/herself to a hospital for diagnosis or treatment of a mental disorder, the hospital must either release the child or commence a commitment proceeding. The hospital may detain the child until the application for a commitment is heard, or twenty-five days, whichever is longer.[35]

Can the hospital provide emergency treatment without parental consent?

Yes. Parental consent is not required if the condition is of an "extremely critical nature," or "to prevent serious harm to the child."[36]

Can a minor be admitted as a "voluntary patient?"

A minor sixteen years of age or older is considered an adult for purposes of inpatient mental health treatment and can therefore be admitted as a "voluntary patient" without parental consent, which would entitle him/her to protections afforded under the Patient's Bill of Rights.[37] Additionally, any patient under sixteen years of age whose parent or legal guardian applies in writing for observation, diagnosis or treatment may be admitted as a "voluntary patient."

Can a minor sign himself/herself out of a psychiatric hospital?

Yes, if he or she is fourteen or older[38], and he or she does not present a danger to self or others in the community.

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[32] Conn. Gen. Stat. §17a-79.
[33] Conn. Gen. Stat. §17a-75.
[34] Conn. Gen. Stat. §17a-540(d).
[35] *Id.*
[36] Conn. Gen. Stat. §17a-81.
[37] Conn. Gen. Stat. §17a-540 through §§17a-550
[38] Conn. Gen. Stat. §17a-79(a).

Reproductive Health Care

Birth Control

How old does a person have to be to obtain birth control?

Any person of any age can obtain birth control in Connecticut without parental consent. There is no minimum age.[39] Note, however, the duty to report sexual activity to child welfare authorities, below, for minors less than thirteen years of age.

Must parental consent be obtained or must parents be notified for the provision of birth control to a minor?

The law does not require either parental consent or parental notification to obtain birth control. Individual clinics or doctors can request that a minor inform her parents upon obtaining contraceptives, but no law mandates such notification.

Am I required to report the sexual activity of a child under a certain age to a parent or legal authorities if the child requests birth control and appears to be sexually active?

This is an example of where the confidentiality laws and the state's child welfare laws conflict. While the clinical provider must not reveal confidential care and treatment of a minor in protected areas (such as birth control) regardless of the child's age, the state's mandatory reporting of child abuse/neglect policies require that mandatory reporters notify the state Department of Children and Families *or* law enforcement officials if a child under the age of thirteen is involved in sexual intercourse or sexual activities. Thus, the use of birth control by a twelve year old patient would mandate a report to DCF or law enforcement. A child thirteen years of age or older requesting or utilizing birth control would not mandate a report of child abuse/neglect *per se*, but would require the clinician to make an individual evaluation of each case to determine whether abuse, neglect, or imminent risk of harm has occurred. See *Mandated Reporting: The Requirements* on page 21 of this book.

Pregnancy

Does a minor need permission from a parent or legal guardian to obtain a pregnancy test? Must the parents be notified of such a test?

No, there is no requirement for parental consent for a pregnancy test as it is considered a routine medical procedure that does not require informed consent. In addition, the law does not require that parents be notified of such a test.

May a minor make a decision herself whether to carry the pregnancy to term?

Yes.

May a minor receive routine gynecological care for pregnancy without parental consent?

Yes, she does not need parental consent for routine gynecological examinations. In addition, a minor may receive confidential treatment for delivery and postpartum care.[40]

Does a minor need permission from a parent or legal guardian to obtain amniocentesis, an epidural, or other invasive procedures?

This is a gray area that cannot easily be answered under the current state of the law. It is likely that an amniocentesis or edpidural would be viewed as a procedure that must remain confidential as it inherently affects reproductive rights and is part of reproductive health care. This falls in line with the AMA Code of Ethics which encourages physicians to respect the judgement and decision-making abilities of "competent minors." On the other hand, an amniocentesis or epidural might be viewed as a "procedure" which would require parental consent under the theory that a minor does not have the legal standing to provide such consent. This remains an unsettled question under the current state of the law. See *Medical or Surgical Treatment* on page 10 of this book.

Reproductive Health Care

Counseling

Is there a requirement that minors obtain parental consent prior to obtaining reproductive health counseling services?

Minors may seek assistance through individuals (at schools, community groups, etc.) on an informal basis without regard to their age. Minors who seek assistance from a professional counselor[41] may do so without parental consent for up to six sessions without requiring the consent or notification of a parent or guardian if the provision of treatment is clinically indicated and the failure to provide treatment would be detrimental to the minor's health and well-being.[42] After six sessions of outpatient treatment, the professional counselor must notify the minor that the consent, notification or involvement of a parent or guardian is required to provide continued treatment[43]. A provider may waive such notification if, in her judgement, notification would be "seriously detrimental to the minor's well being" and a redetermination as to notification would be required after six additional sessions.[44] *See* page 12 of this book.

Who is responsible for payment for such services?

The minor is responsible for payment for counseling services. A parent or guardian who is not informed of treatment for a minor child is not liable for the costs of the treatment provided.[45] In addition, a parent may not be billed for such services.

Emergency Contraception / Morning-After Pill

Must a minor obtain parental consent for the disbursement of emergency contraception (i.e. the morning after pill)?

No. Parental consent is not required for the disbursement of emergency contraception. However, a minor requires a prescription to obtain emergency contraception from a pharmacy. Once the minor turns eighteen, the emergency contraception may be obtained over-the-counter without a prescription.

What is a patient's right to emergency contraception if she is a victim of a sexual assault?

Under a law enacted by the Connecticut Legislature in 2007, hospital emergency departments must provide access to emergency contraception on-site when requested by a victim of sexual assault.[46] This law generated significant controversy due to the opposition by the state's Catholic hospitals, but, as of this writing, the Catholic hospitals have agreed to provide victims of sexual assault with emergency contraception.

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[39] Although Connecticut law is silent on this subject, the constitutional protections afforded minors on privacy grounds are dispositive. *See Carey v. Population Service Int'l.* 431 Y,/ s,678 (1977); *Bellotti v. Baird,* 443 U.S.622 (1979).

[40] Although Connecticut law is silent on this aspect of medical care/treatment as well, the constitutional authority granting minors absolute confidentiality and autonomy over reproductive health care decisions is inviolate. *See* footnote 41, supra, and *Roe v. Wade,* 410 U.S.113 (1973).

[41] Professional counselor includes a psychiatrist, psychologist, independent certified social worker, or licensed marital and family therapist. Conn. Gen. Stat. §19a-14c(b).

[42] *Id.*

[43] *Id.* at 14c(c).

[44] *Id.* The pattern of notification after six sessions continues until the counselor determines that notification would no longer be "seriously detrimental to the minor's well being." Id.

[45] *Id.* at 14c(d).

[46] P.A. No. 07-124.

Reproductive Health Care

Abortion

Must a physician obtain the informed consent of a parent prior to terminating the pregnancy of a minor?

Parental consent is not required prior to the performance of an abortion on a minor. For purposes of this statute, a minor is defined as a person less than sixteen years of age.[47] A physician or counselor[48] must explain to the minor that the information given is not intended to coerce, persuade or induce a decision; explain the choices available to the minor (e.g., carrying the pregnancy to term, placing the child for adoption, having an abortion, etc.); discuss the possibility of involving the minor's parents in the decision-making process and whether the minor believes that involvement would be in the minor's best interest.[49] Note that these requirements do not apply when a medical emergency exists that creates a danger to the health and well-being of the minor so as to require an immediate abortion[50].

Must the minor sign indicating receipt of the information?

Yes.

May a minor terminate a pregnancy at any time during pregnancy?

Connecticut law in unspecific as to the limits of pregnancy termination other than to proscribe that a pregnancy may not be terminated after viability of the fetus except when necessary to save the life or health of the pregnant woman[51].

What is the abortion pill?

The abortion pill, also known as RU-486, is a drug approved by the Food and Drug Administration as a non invasive means to terminate a pregnancy. The abortion pill, which is actually two different pills taken a few days apart, works by causing the uterus to dispel a fertilized egg.

Must a minor obtain parental consent for the disbursement of the abortion pill?

While there is no statute or regulation in Connecticut that deals precisely with the means and mechanisms of the abortion pill, it appears likely that a minor may obtain this method of pregnancy termination without parental consent, as it is likely that this would also be considered an "abortion" as per Connecticut statute and the inherent Constitutional guarantee of the right to an abortion. *See* Conn. Gen. Stat. § 19a-600 *et seq.* and *Roe v. Wade*, et al.

Where can a minor obtain the abortion pill?

The abortion pill must be prescribed by a nurse practitioner, physician assistant, or physician. Minors should be aware that this medication, unlike the "morning after pill" *is not* available over-the counter at a pharmacy.

Will a minor who seeks treatment in Connecticut still be able to obtain an abortion without parental consent if *Roe v. Wade* is overturned by the United States Supreme Court?

Since the right to an abortion is governed by statute in Connecticut, any decision by the United States Supreme Court involving *Roe v. Wade* will not impact the minor's right to seek termination of a pregnancy in Connecticut. However, the legislature might enact a provision which could limit access to abortion by minors (e.g. parental consent or notification requirements). These limitations have been enacted in other states and upheld by the United States Supreme Court.

Reproductive Health Care

Sexually Transmitted Diseases and Infections

Must a health care provider obtain parental consent to examine or treat a minor for a sexually transmitted disease?

No. A minor can be examined and treated for a sexually transmitted disease (STD) without parental consent.[52] The consultation, examination, and treatment of a minor is confidential and must not be divulged to the minor's parents or guardian, including the sending of a bill for services to anyone other than the minor.[53] The provider is obligated to report any disease on the Health Commissioner's "list of reportable diseases" to the Department of Public Health within twelve hours after recognition of the disease, and to the town health director.[54]

Who is liable for the costs?

The minor is liable for all costs and expenses resulting from the diagnosis and treatment of the STD.[55]

Are there any circumstances under which DCF must be notified?

Yes. If the child is twelve years of age or under, DCF must be notified as to the name, age, and address of the child.[56] In this circumstance, the examination, care and treatment of the minor must remain confidential, although DCF may proceed with an investigation to determine whether child abuse or neglect has occurred.[57]

Physical Exams, Including Pap Smears

Does a minor need parental consent to undergo a physical exam, including a pap smear?

No. Connecticut law does not require parental notification for minors who wish to undergo an examination (including gynecological) or to obtain a pap smear.[58]

Must a health care provider inform a parent if a minor's pap smear is abnormal?

There is no statutory requirement that a minor's parents or legal guardian be informed of an abnormal pap smear. Note, however, that parental notification may be ethically justified if the minor will face a serious health threat, and there is reason to believe the parents/guardian will be helpful and understanding.[59] This is another gray area that remains an open question under the current state of the law.

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[47] Conn. Gen. Stat. §19a-600(2). This is different from most of the statutes referred to in this manual that define "minor" as under eighteen years of age.
[48] Counselor includes a psychiatrist, a licensed psychologist, licensed clinical social worker, licensed marital and family therapist, ordained clergy member, licensed physician's assistant, nurse-midwife, certified guidance counselor, registered nurse, or practical nurse. Conn. Gen. Stat §19a-600.
[49] Conn. Gen. Stat. §19a-601(a).
[50] *Id.* at 601(e).
[51] Conn. Gen. Stat. §19a-602.
[52] Conn. Gen. Stat. §19a-216.
[53] *Id.*
[54] *Id.* at §19a-215.
[55] Conn. Gen. Stat. §19a-216(b).
[56] Conn. Gen. Stat. §19a-216(a).
[57] *See* Conn. Gen. Stat. §17a-101(g).
[58] *See* section on Medical and Surgical Treatment, supra.
[59] AMA Current Opinions of the Council on Ethical and Judicial Affairs, E-5.055.

Emancipation and Access to Health Insurance

How does a minor become emancipated?

A minor sixteen or seventeen can petition the Juvenile Court or Probate Court for an emancipation order.[60]
A court may emancipate a minor if:

- the minor has been married;
- the minor actively serves in the U.S. Armed Forces;
- the minor willingly lives away from home with or without parental consent and manages his or her own finances; or
- the court determines "for good cause" that emancipation is in the "best interest" of the minor.[61]

Under what circumstances is a minor considered "emancipated" under common law?

Under common law (i.e. deriving from tradition in the courts rather than from a statute), a minor is considered "emancipated" if the youth enters a living arrangement that is inconsistent with his/her being in a subordinate situation in the parents' immediate family. The new living arrangement must result from the parents' relinquishment of the right to control the youth's circumstances and earnings. The relinquishment may be express or implied by the parents' actions.[62] Note, however, that Connecticut courts, to date, have not recognized common law emancipation.

What are the medical consequences if a minor is emancipated?

If a minor is emancipated by court order, a minor may consent to "medical, dental or psychiatric care without parental consent, knowledge or liability." [63]

Does this mean that if a minor is "emancipated" the parent is not liable for the costs of the medical care?

Yes. The parent is not liable.[64]

How does an "emancipated minor" differ from a "mature minor"?

There are no statutes or any published case in Connecticut which recognize a "mature minor" as in other states, except as it relates to receipt of outpatient mental health treatment or release from a psychiatric facility.[65] States that recognize the "mature minor" rule permit treatment of minors sufficiently mature to give their own consent. This usually applies to older adolescents. Courts in other jurisdictions consider the severity of the condition, require that the treatment benefit the minor, and weigh the minor's ability to comprehend the nature, risks, and likelihood of success of the procedure.[66]

How does a health care facility/clinic know that a minor is emancipated? In other words, should the facility take the word of a minor or accompanying individual that the minor is emancipated?

Emancipated minors should present their emancipation order, duly signed by a judge of the Superior or Probate court, as evidence that they are emancipated. The Order is simply a piece of paper from the appropriate court, signed by a judge, that verifies the emancipation order. Prudent clinicians should not accept the word of a minor that s/he is emancipated without presentation of the court order.

May an emancipated minor obtain health insurance coverage in his/her own name?

Minors, **whether emancipated or not**, may apply for and receive medical insurance from the state under the "HUSKY A" plan (Medicaid) if they are under nineteen years of age. Minors whose income exceeds the eligibility requirement for HUSKY A coverage (over 185% of the federal poverty rate) must be emancipated in order to qualify for coverage under the "HUSKY B" program.[67]

Is a sixteen or seventeen year old who "signs out" of DCF care "emancipated?"

No. Absent a valid emancipation order, a sixteen or seventeen year old who leaves DCF custody is not an emancipated minor under state law.

Privileged Communications

Physician/Patient Privilege

When are communications between a physician or health care provider and patient privileged?

They are privileged except:

- if a claim is made against a physician;
- child or elder abuse is involved, or abuse of an individual who is physically disabled or incompetent, or abuse of an individual with mental retardation is known or in good faith suspected; and,
- there is an investigation of a complaint by the Commissioner of Public Health.[68]

Does this mean that communications between a physician or patient can never be disclosed unless it fits into the three categories listed above?

No. A "privileged" communication is one which cannot be divulged **in a court of law** without the patient's permission or unless it fits into the statutory exceptions. A physician can disclose his/her communications to other persons outside a court of law if allowed under the code of ethics for his/her profession, unless prohibited by other provisions of law.[69]

If a minor patient reveals to a physician that s/he is suicidal or that s/he has hurt him/herself, can a physician disclose this information to the parents or anyone else?

Connecticut statutes do not address this question directly for physicians other than psychiatrists (see Psychiatrist/Patient Privilege on the following page of this publication). Therefore, the physician must rely on his/her own code of medical ethics which indicates that disclosure may be appropriate.[70] Traditionally, physicians are encouraged to reveal a patient's danger to self or others to avoid liability consequences. *See Tarasoff v. Regents of the Univ. of Calif. 17 Cal. 3d 425 (1976).*

What if the minor discloses that s/he was raped?

If the minor discloses that s/he was sexually assaulted (forced to engage in sexual relations against his/her will), or a sexual relationship was the result of a parent's neglect, the physician/patient privilege does not apply since this is a "reportable offense to DCF" under the mandated reporting laws governing child abuse.[71]

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[60] Conn. Gen. Stat. §46b-150b.
[61] Conn. Gen. Stat. §46b-150d.
[62] *See Wood v. Wood*, 63 A.2d 89 (Conn. 1948); *State v. Plude*, 621 A.2d. 1342 (Conn. App. Ct. 1993); *Mills v. Therault,* 499 A.2d 89 (Conn. Super. Ct. 1985).
[63] Conn. Gen. Stat. §46b-150d(a).
[64] *Id.*
[65] *See* Conn. Gen. Stat. §§19a-14c and 17a-504; *Melville v. Sabbatino*, 313 A.2d 886 (Conn. Sup. Ct. 1973) in which the court recognized the ability of minors aged sixteen and over to consent to their release from psychiatric treatment.
[66] *See*, e.g. *Younts v. St. Francis Hospital and School of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970); *In re R.G.* 549 N.E.2d 322 (Ill.1989).
[67] Minors with questions about HUSKY eligibility are encouraged to call 1-877-CT-HUSKY (1-877-284-8759).
[68] Conn. Gen. Stat. §52-146o.
[69] *See* e.g. AMA Current Opinions of the Council on Ethical and Judicial Affairs E-5.05, Confidentiality; and E-8.08, Informed Consent.
[70] *See* e.g. AMA Current Opinions of the Council on Ethical and Judicial Affairs E-5.05, Confidentiality, for waiver of confidentiality if minor indicates "serious bodily harm to another person or to him or herself," and E-5.055, Confidentiality Care for for Minors.
[71] *See* Memorandum to Hotline Staff from Ken Mysogland, Hotline Director, July 16, 1998; DCF Policy Manual, Child Protective Careline, §33-7-6, available at the Center for Children's Advocacy at *www.kidscounsel.org*.

Privileged Communications

Psychologist/Patient Privilege

Are communications between a psychologist and patient privileged communications?

They are privileged under the law and cannot be disclosed unless one of the following occurs:

- they are made for the purposes of a court-ordered psychological examination;
- in a civil proceeding, the psychological condition is an element of the claim or defense;
- the psychologist determines there is risk of imminent personal injury to the person or other persons, or risk of imminent injury to the property of others. In this case, a psychologist may disclose the communication; or,
- child abuse, elder abuse, or abuse of an individual who is disabled or incompetent is known or in good faith suspected.[74]

Psychiatrist/Patient Privilege

Are communications between a psychiatrist and patient privileged communications?

Connecticut law permits psychiatrists to disclose communications or records of a patient in these circumstances:

- to another mental health facility to which the patient is admitted if the psychiatrist determines that the disclosure is needed to accomplish the objectives of diagnosis or treatment;
- when the psychiatrist determines that there is a substantial risk of imminent phsyical injury by the patient to him/herself or others;
- in a dispute over fees or claims for services provided to a patient;
- in the course of an examination made in connection with the application for the appoint ment of a conservator by the Probate Court for "good cause shown;"
- in a civil proceeding in which the patient introduces his/her mental condition as an element of the claim or defense; or,
- to a member of the immediate family or legal representative of the victim of a homicide committed by the patient.

Are communications between a psychiatrist and a patient's family member covered by the privilege?

Yes, as long as the communications relate to diagnosis or treatment.[77]

What recourse does a patient have if the psychiatrist/patient privilege is violated?

A patient may petition the Superior Court for appropriate rellief including a temporary and permanent injunction and/or damages.[78]

[74]Conn. Gen. Stat. §52-146c.
[75]Conn. Gen. Stat. §52-146f.
[76]Compare Conn. Gen. Stat. §52-146f(2) with Conn. Gen. Stat. §52-146(c)(3).
[77]Conn. Gen. Stat. §52-146d(2);(6).
[78]Conn. Gen. Stat. §52-146j.

Mandated Reporting: The Requirements

Who is a "mandated reporter" under the law?

A mandated reporter is any physician or surgeon licensed in the state, any resident physician or intern in any hospital in the state (whether licensed or unlicensed), a registered nurse, a licensed practical nurse, medical examiner, dentist, dental hygienist, psychologist, school teacher, school principal, school guidance counselor, school paraprofessional, school coach, social worker, police officer, juvenile or adult probation officer, juvenile or adult parole officer, member of the clergy, pharmacist, physical therapist, optometrist, chiropractor, podiatrist, mental health professional or physician assistant, licensed or certified emergency medical services provider, licensed or certified alcohol and drug counselor, licensed marital and family therapist, sexual assault counselor or battered women's counselor, licensed professional counselor, person paid to care for a child in any public or private facility, child day care center, group day care home, or family day care home licensed by the state, any employee of the Department of Children and Families, any employee of the Department of Public Health who is responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps, the Child Advocate, and any employee of the Office of the Child Advocate.[79]

What must be reported to DCF by the "mandated reporter?"

Mandated reporters, who, in the ordinary course of their employment, have reasonable cause to suspect or believe that a child has been abused or neglected, or is at imminent risk of serious harm, are required to report the abuse/neglect/risk of imminent harm to DCF or law enforcement officials.[80]

What are the definitions of abuse and neglect?

A mandated reporter must notify DCF or law enforcement when any of the following have occurred to a child under eighteen:

- **Abuse, which constitutes:**
  - non-accidental physical injury;
  - injury that conflicts with a reported injury;
  - a condition which is the result of maltreatment such as malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment.[81]

- **Neglect, which constitutes:**
  - a child who has been abandoned;
  - a child not properly cared for physically, educationally, emotionally, or morally;
  - a child who is permitted to live under conditions or circumstances or associations injurious to his/her well-being.[82]

- **Non-accidental physical injury**

- **Imminent risk of serious harm**

What is the penalty for failure to report suspected child abuse or neglect?

Mandated reporters who fail to report are subject to a fine not less than $500 but not to exceed $2500. Mandated reporters who fail to report must participate in an education and training program at their own expense.[83]

How long does a mandated reporter have to make a report to DCF after discovering the abuse/neglect?

Mandated reporters must make a report to DCF (800-842-2288) or law enforcement no later than 12 hours after discovering the abuse/neglect.[84] Within 48 hours of making an oral report, a mandated reporter must submit a written report to DCF.[85]

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[79] Conn. Gen. Stat. §17a-101b.
[80] Conn. Gen. Stat. §17a-101a.
[81] Conn. Gen. Stat. §17a-101a, 46b-120.
[82] *Id.*
[83] Conn. Gen. Stat. §17a-101a
[84] Conn. Gen. Stat. §17a-101b.
[85] Conn. Gen. Stat. §17a-101c.

Statutory Rape

What is statutory rape?

Statutory rape is statutorily defined sexual assault that takes many different forms. The most common type of statutory rape is consensual sexual intercourse involving a minor under sixteen years of age.[86] The basic components of statutory rape are:

Sexual Assault in the First Degree
When a person engages in sexual intercourse with a person under thirteen years of age and the "actor" is more than two years older than the other person (whether the act is consensual or not).

Sexual Assault in the Second Degree
(Effective October 1, 2007)
When a person engages in sexual intercourse with another person and the person is thirteen years of age or older, but under sixteen years of age, and the "actor" is more than three years older than the other person (whether the act is consensual or not).[87]

Sexual Assault in the Fourth Degree
(Effective October 1, 2007)
When an "actor" (a) intentionally subjects a person under thirteen years old and more than two years younger to sexual contact, or (b) intentionally subjects a person who is older than thirteen years old but younger than fifteen years old to sexual contact and the "actor" is more than three years older. Prior to October 1, 2007, sexual assault in the fourth degree only required that the person subjected to sexual contact be less than fifteen years old, regardless of the age difference.[88]

Does it matter if the minor "victim" lied about his or her age?

No, it doesn't matter if the person lied about age. The statute does not provide a defense to an "actor" who claims deception by a minor into having consensual sexual intercourse.[89]

Is statutory rape a crime that requires mandatory reporting under Connecticut law?

The law requires that all cases of suspected abuse and neglect be reported to DCF or law enforcement and the definition of abuse includes "sexual molestation."[90] It is an open question as to whether a statutory rape offense constitutes "sexual molestation" pursuant to Connecticut law. Therefore, it remains a matter of professional judgment as to whether statutory rape mandates a report and, pursuant to Conn. Gen. Stat. §§ 17a-101 et. seq., evaluations of abuse and neglect must be determined on a case-by-case basis. DCF previously issued guidelines indicating that statutory rape is not a reportable offense unless the "rape is intrafamilial, or if the rape is the result of parental neglect."[91] In all cases involving a minor twelve years of age or younger, the name and address of the minor "victim" must be reported to DCF.

In a September 30, 2002 letter to the DCF Commissioner, the State of Connecticut's Attorney General confirmed DCF's interpretation of what constitutes a "reportable offense" when "statutory rape" laws are invoked. The essence of these interpretations is as follows:

- All instances of consensual sexual activity involving a minor 12 or younger must be reported to either DCF or a local law enforcement agency;
- When a minor older than 12 and younger than 16 engages in consensual sexual activity with a partner 21 or older, the activity must be reported to either DCF or a local law enforcement agency;
- Instances of sexual activity between a minor older than 12 but younger than 16, with a partner who is more than two years older **(three as of October 1, 2007)** but under 21, does not require mandatory reporters to automatically report this activity to DCF. As defined by statute (Conn. Gen. Stat.§ 17a-101a), reporters are to use professional judgment to assess the situation to determine whether abuse or neglect has occurred.
- In considering whether to report consensual sexual activity between minors, the reporter should consider the relative ages of the individuals in question. The greater the disparity in age between the individuals, the greater likelihood that a reporter will have reasonable basis to suspect abuse or neglect.[92]

Access to Medical Records

Does a minor have a right to obtain his/her medical records from a doctor, hospital, or other health care provider?

Connecticut law provides that "a patient" is entitled to complete access to all medical records concerning his diagnosis, treatment and prognosis.[93] A patient is defined under the statute as a "natural person who has received health care services from a provider ..."[94] Though the statute remains silent as to a minor's right to access medical records, it appears likely that a minor would be able to access his/her records without parental consent, subject to the exceptions noted below.

Does the patient have an absolute right to view his/her records?

If the provider reasonably believes that the information may be detrimental to the physical or mental health or well-being of the patient, or if the provider believes that the patient is likely to cause harm to others as a result of viewing the information, the provider may withhold the information from the patient.[95] The patient then has the right to petition the Superior Court for an order compelling the medical provider to release the information.[96]

Where one parent has legal custody of a child, is the non-custodial parent entitled to obtain the child's medical records from a health care provider?

A non-custodial parent retains the statutory right to obtain his/her child's medical records, absent an order from the Superior Court.[97] A non-custodial parent whose parental rights were terminated by the Superior Court would not be entitled to obtain these records.[98]

May a provider release medical records to another provider without the patient's permission?

This is gray area which combines the statutory proscriptions enacted by the Connecticut legislature with the provisions of HIPAA (see page 25). Under Connecticut law, a copy of the patient's health record, including but not limited to x-rays and copies of laboratory reports, prescriptions and other technical information used in assessing the patient's condition, shall be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The patient shall be responsible for the reasonable costs of furnishing the information.[99] However, providers should be aware that under certain circumstances governed by HIPAA, the records may be provided to other clinicians without the patient's consent. Providers are urged to seek counsel from their risk management team, or legal counsel, regarding transfer of records to other providers without the patient's consent.

Does this provision apply to immunization records provided to the Department of Public Health (DPH)?

No. A healthcare provider who intends to administer vaccines to any child listed on DPH's registry of immunizations, or any parent or guardian of such child, may obtain the current information contained on the registry for purposes of determining whether additional doses of immunizations are needed, or to clarify immunization status for schools or day care facilities.[100]

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[86] *See* Conn. Gen. Stat. §§53a-70, 71.
[87] *See* Conn. Gen. Stat. § 53a-71 *as amended* by P.A. 07-143. This statutory revision changed the age differential for sexual assault in the second degree from two to three years.
[88] *See* P.A.07-143, §2 amending Conn. Gen. Stat. §53a-73a (Sexual Assault in the Fourth Degree).
[89] *See* Conn. Gen. Stat. §§53a-67.
[90] *See* Conn. Gen. Stat. §§46b-120.
[91] *See* footnote 73, *supra.*
[92] *See* letter from Attorney General Richard Blumenthal to DCF Commissioner Kristine Ragaglia dated September 30, 2002.
[93] *See* Conn. Gen. Stat. §20-7c.
[94] *Id.* at §20-7b.
[95] *Id.* at §20-7b/b.
[96] *Id.*
[97] *See* Conn. Gen. Stat. §46b-56. See also *Doe v. Doe*, 244 Conn. 403, 420 (1997).
[98] *Id.*
[99] Conn. Gen. Stat. §20-7d.
[100] Conn. Gen. Stat. §19a-7h. *See also* Department of Public Health Code §§19a-7-1 and 2.

School Based Health Clinics

What are school based health clinics?

School based health clinics (SBHCs) are comprehensive primary health care facilities located within or on the grounds of schools. They are located in high schools, middle schools and elementary schools, and are licensed outpatient clinics pursuant to Title 19-12-D45 through 19-13-53, Regulations of Connecticut State Agencies.

Are SBHCs similar to other hospital or community related clinics as defined by the state?

Yes, SBHCs are defined as outpatient clinics pursuant to the DPH regulations. Each SBHC contains a multi-disciplinary team of professionals with particular expertise in child and adolescent health care – i.e. nurse practitioner, physician, social worker, prevention specialist, and, in some cases, dentist and dental hygienist, nutritionist, health educator, outreach worker, etc.[101]

Can parents obtain their child's medical records from the SBHC?

Yes, but only under limited circumstances. Connecticut law authorizes parents to obtain "all ... medical ... records maintained" in a student's file, except for those records classified as privileged.[102] The privilege described in the statute applies to a "professional communication" made between a teacher or nurse and a student when the information concerns "alcohol or drug abuse or any alcoholic or drug problem."[103]

Do the privileges and protections afforded by the confidentiality statutes and principles described in the preceding sections (e.g. reproductive health care, STD and HIV testing, etc.) apply to SBHCs?

It appears likely that all of the confidentiality and privacy protections described in the preceding sections apply to SBHCs as well as traditional medical providers. Since SBHCs are licensed outpatient clinics pursuant to the Public Health Code, all of the confidentiality protections afforded under state and federal law apply to this setting.[104]

Often, the reality of school based clinics demands that a general consent to treat, signed by a parent or legal guardian, be obtained before the clinic can see a minor in the school-based setting. Note, however, that the laws mandate that parental consent *is not required* when a minor seeks the type of treatment elaborated upon in this book as confidential (*see e.g.* reproductive rights, STD diagnosis and treatment, counseling, etc.). This tension, between the SBHC's requirement of a general consent to treat signed by a parent/guardian and the minor's confidential right to care and treatment, often leads to minors foregoing treatment at SBHCs.

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[101] Department of Public Health Code §§19-12-D45 through 19-13-53.
[102] Conn. Gen. Stat. §10-15b(a).
[103] *Id.* at §10-154a.
[104] *See* OLR Research Report, *School Based Health Centers. go to www.ct.gov and type "OLR Research Report School Based Health Centers" into search box.*
[105] 45 CFR §160.103.
[106] 45 CFR §164.502(g)(3)(i-ii).
[107] An example is a 16 year old who goes, with her mother, to a gynecologist for an exam and to discuss contraceptive use. In this case, the teen controls health information relating to contraceptive services as long as she is legally entitiled to obtain services on her own (as in Connecticut), and regardless of whether the mother consents.
[108] An example is an adolescent who visits the pediatrician with a parent/guardian for a routine physical exam. Under protocol developed by the AAP, during the exam the pediatrician should raise questions about risk-taking behavior such as drug and alcohol use and sexual activity. Typically, the parent provides consent to this exam, but the pediatrician explains to both the parent and the minor that the exam should be private and that the pediatrician will keep the minor's confidences. Where the parent assents to this agreement, the minor, and not the parent, will have the right of access to and control over health information covered by the agreement. *See* 45 CFR §164.502(g)(3)(iii).
[109] *See id*. at §§164.502(g)(5), 164.524(a)(3)(iii).
[110] *See id*. at §164.502(g)(3)(ii)(C).

Privacy Rights: HIPAA and Minor's Right to Confidentiality

What is the Health Insurance Portability and Accountability Act (HIPAA) and does it affect minors' confidentiality rights?

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II requires the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions, and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Confidential health care services are included in these standards.

What is a covered entity under HIPAA?

HIPAA applies to the following entities:

- health plan (e.g. group health plan, health insurance issuer, HMO, recipients of Medicare Part A or Part B, Medicaid recipients, etc.);
- health care clearinghouse (i.e. medical data processing facility);
- health care provider.[105]

How do HIPAA regulations impact on the existing state confidentiality provisions regarding reproductive rights, testing, mental health, etc.?

HIPAA regulations preserve existing practices with respect to minors, and in so doing, strike an appropriate balance between the need for parents to have access to their children's health information and the need for minors to keep some information private.

Under HIPAA regulations, parents will generally have access to and the right to control their children's health information, subject to three important exceptions that serve to protect minors' confidentiality.

What are the exceptions that serve minors' confidentiality?

There are three exceptions:

- The minor, and not the parent, will have the right of access to and control over his/her health information concerning health services that s/he may lawfully obtain without parental consent.[106] These are the confidential services and treatment that Connecticut minors may obtain without parental permission, such as testing for STDs, HIV testing and treatment, etc. Note that a minor's voluntary involvement of a parent in seeking a health service does not change his/her right to control the related information.[107]
- The regulation preserves and respects the existing practice of allowing parents, their children, and health care providers to enter into agreements enabling the health care professional to provide confidential care to the minor.[108]
- The regulation provides important protections for circumstances in which allowing parent access to a minor's health information will endanger the minor. (e.g. a provider who believes that a minor was subjected to abuse or neglect by a parent/guardian, or believes that release of medical information my endanger a minor, may withhold medical information from the parent/guardian).[109]

Can a parent/legal guardian access information about a minor's health care without the minor's consent?

Where no state law or other law governs parental access to the minor's protected health information, HIPAA regulations give health care professionals discretion to grant or deny the parent/legal guardian such access.[110]

Privacy Rights: HIPAA and Minor's Right to Confidentiality

What happens if the HIPAA regulations conflict with or contradict existing state regulations regarding confidentiality?

Generally, the federal rule preempts state law unless state law is more protective of an individual's privacy. However, in the case of minors, the rule specifically defers to state laws that either authorize or prohibit disclosure of confidential information about minors to parents, guardians, or persons acting *in loco parentis*.[111]

Do the regulations apply to the reporting of child abuse and neglect?

No. Such reporting continues to be governed exclusively by state law. The regulation imposes no obligation on entities that report child abuse or neglect to advise the child of the report – even when the child is an older teenager.

Absent the protections afforded to minors that are covered in this book, does HIPAA prohibit medical providers from speaking with family and friends about a patient's health condition absent the patient's objection?

Contrary to popular belief, HIPAA does not preclude medical professionals from talking to family and friends – and a signed release or authorization is ***not*** required for professionals who wish to share information with family, relatives, friends, or others identified by the patient.[112]

Where can I obtain more information about the new HIPAA regulations?

The most comprehensive source of information about HIPAA, though somewhat difficult to navigate, is the U.S. Department of Health & Human Services' Office of Civil Rights HIPAA web site at *www.hhs.gov/ocr/hipaa*.

A good source of information regarding HIPAA and civil rights issues is *Answers to Frequently Asked Questions about Government Access to Personal Medical Information (under the USA Patriot Act and the HIPAA regulation)* available at *www.aclu.org/privacy/medical15222res20030530.html.*

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[111] *See id*. at §§160.202 and 160.203.
[112] *See* 45 CFR §164.510.
[113] *See* Conn. Gen. Stats. §§ 19a-570 *et seq.*
[114] Conn. Gen. Stat. §19-580
[115] American Academy of Pediatrics Committee on Bioethics, Informed Consent, Parental Permission and Assent in Pediatric Practice, 95 Pediatrics 314, 314-317 (1995), *available at* http://pediatrics.aappublications.org/cgi/content/abstract/95/2/314
[116] Conn. Gen. Stat. § 46b-150 *et seq.*

Advanced Directives and Living Wills: End of Life Decisions

What are the legal definitions of "Advanced Directives?"

"Advanced Directives" are written instructions, such as a living will or durable power of attorney, which are recognized under Connecticut law to express a person's wishes as to his/her health care in the event the person is unable to make or communicate treatment decisions. Advanced directives may include a living will or health care instructions, the appointment of a health care agent, the appointment of an attorney-in-fact for health care decisions, appointment of a "conservator of the person," and instructions for organ donation.

A living will is a legal document that states a person's wishes regarding any aspect of his/her health care, including the withholding or withdrawal of life-support systems.[113]

What are life-support systems?

Life-support systems refer to any medical procedure or intervention which serves only to postpone the moment of death or maintain the person in a state of permanent unconsciousness. Examples of life-support systems include mechanical or electronic devices (e.g. ventilators) and artificial means of providing nutrition or hydration, such as a feeding tube. In regard to decisions about the removal of life support systems, physicians are required by law to make reasonable efforts to notify the individual's health care agent, legal guardian, conservator, next-of-kin, or person they have designated to make medical decisions on their behalf, if such person is available.[114]

Can a minor execute valid end of life directives?

No. In Connecticut, a person must be eighteen or older to sign a legal document containing health care directives. Because parents/legal guardians are empowered by law to make health care decisions for minors, health care directives are not legally necessary for minors. However, minors may be involved in the decision-making process and express their wishes to those who will ultimately make health care decisions for them.

What about end of life decision making for the unemancipated minor – who gets to make the decisions regarding life support systems, including nutrition and hydration?

While each case is different, the guiding principle of law is that minors do not have the legal capacity to direct their care, including end of life decision making, on an independent basis. While a minor's parents or legal guardians are the legally responsible decision makers in these cases, there are those in the medical community who share the opinion expressed by the American Academy of Pediatrics that minors, as patients, "have a moral and legal right to refuse proposed medical intervention …" and that "[r]espect for competent patients' autonomy ordinarily extends even to the refusal or discontinuation of their own life-sustaining treatment."[115]

Can a minor who is emancipated pursuant to a valid Connecticut court order execute a legally valid living will or other advanced directives?

This is an open question that has not been resolved by a Connecticut court to date. The statutes governing the execution of a living will and those providing direction for the emancipation of a minor do not specifically answer this question,[116] although emancipated minors have the right to consent to medical care without parental consent, knowledge, or liability. It is probable that a physician would take into account any evidence of the emancipated minor's wishes expressed prior to becoming "permanently unconscious," as directed by the governing statutes.

Where can I learn more about Connecticut law regarding advanced directives and health care decisions – especially about the forms which are used to execute a living will or the appointment of a health care representative?

The state office of the Attorney General and the Departments of Social Services and Public Health have produced a helpful booklet entitled *Your Right to Make Decisions – A Summary of Connecticut Law*, available at *www.ct.gov/ag/lib/ag/health yourrightstomakehealthcaredecisions2006version.pdf.*

List of Useful Publications

American Civil Liberties Union,
Protecting Minior's Health Information Under the Federal Medical Privacy Regulations (2003).

Arshagouni, Paul,
"But I'm An Adult Now ... Sort Of": Adolescent Consent in Health Care Decision-Making and the Adolescent Brain, *9 J. Health Care L. & Pol'y 315 (2006).*

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Taking the Sting Out of Reporting Requirements: Reproductive Health Clinics and the Constitutional Right to Informational Privacy, *56 Duke L.J. 583 (2006).*

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Adolescent Health Care: The Legal Rights of Teens (December 2007).

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Planned Parenthood of Connecticut,
Your Body, Your Rights: A Guide for Connecticut Teens (1999).

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Van Stratten, Justine,
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67 A.L.R. 4th 511 (1989).

Youth Services Bureau of Norwich, Montville, Stonington, Groton, and Prevention Collaborative for Youth, **The Gray Area Revisited: A Primer on the Rights and Responsibilities of Young People in Relation to the Law** (1998).

United States Department of Health and Human Services, **Summary of the HIPAA Privacy Rule**, Office for Civil Rights. Available at *www.hhs.gov/ocr/privacysummary.pdf.*

List of Useful Websites

National

American Academy of Pediatrics
www.aap.org

American Bar Association Center on Children and the Law
www.abanet.org/child

American Civil Liberties Union
www.aclu.org

American Medical Association
www.ama-assn.org

American School Health Association
www.ashaweb.org

Bazelon Center for Mental Health Law
www.bazelon.org

Center for Reproductive Law and Policy
www.crlp.org

Center on Adolescent Health and the Law
www.adolexcenthealthlaw.org

Code of Federal Regulations
www.gpoaccess.gov/cfr/index.html

HIPAA Medical Privacy
www.hhs.gov/ocr/hipaa

National Health Law Program
www.healthlaw.org

Office for Civil Rights,
U.S. Department of Health and Human Services
www.hhs.gov/ocr/hipaa

Planned Parenthood
www.plannedparenthood.org

Society for Adolescent Medicine
www.adolescenthealth.org

Connecticut

Center for Children's Advocacy
www.kidscounsel.org

Connecticut Department of Children and Families
www.state.ct.us/dcf

Connecticut Department of Public Health
www.state.ct.us/dph

Connecticut Department of Social Services
www.dss.state.ct.us

Connecticut General Statutes
www.cga.ct.gov/asp/menu/statutes.asp

Planned Parenthood of Connecticut
www.ppct.org

Appendix: Connecticut General Statutes

(continued on following page)

Appendix: Connecticut General Statutes

Connecticut General Statutes

Listed in Numerical Order

Conn. Gen. Stat. § 1-1d (2007)

"Minor", "infant", "infancy", "age of majority", defined.

Except as otherwise provided by statute, on and after October 1, 1972, the terms "minor", "infant" and "infancy" shall be deemed to refer to a person under the age of eighteen years and any person eighteen years of age or over shall be an adult for all purposes whatsoever and have the same legal capacity, rights, powers, privileges, duties, liabilities and responsibilities as persons heretofore had at twenty-one years of age, and "age of majority" shall be deemed to be eighteen years.

Conn. Gen. Stat. § 10-15b (2007)

Access of parent or guardian to student's records. Inspection and subpoena of school or student records.

(a) Either parent or legal guardian of a minor student shall, upon written request to a local or regional board of education and within a reasonable time, be entitled to knowledge of and access to all educational, medical, or similar records maintained in such student's cumulative record, except that no parent or legal guardian shall be entitled to information considered privileged under section 10-154a.

(b) The parent or legal guardian with whom the student does not primarily reside shall be provided with all school notices that are provided to the parent or legal guardian with whom the student primarily resides. Such notices shall be mailed to the parent or legal guardian requesting them at the same time they are provided to the parent or legal guardian with whom the child primarily resides. Such requests shall be effective for as long as the child remains in the school the child is attending at the time of the request.

(c) If any private or public school is served with a subpoena issued by competent authority directing the production of school or student records in connection with any proceedings in any court, the school upon which such subpoena is served may deliver such record or at its option a copy thereof to the clerk of such court. Such clerk shall give a receipt for the same, shall be responsible for the safekeeping thereof, shall not permit the same to be removed from the premises of the court and shall notify the school to call for the same when it is no longer needed for use in court. Any such record or copy so delivered to such clerk shall be sealed in an envelope which shall indicate the name of the school or student, the name of the attorney subpoenaing the same and the title of the case referred to in the subpoena. No such record or copy shall be open to inspection by any person except upon the order of a judge of the court concerned, and any such record or copy shall at all times be subject to the order of such judge. Any and all parts of any such record or copy, if not otherwise inadmissible, shall be admitted in evidence without any preliminary testimony, if there is attached thereto the certification in affidavit form of the person in charge of such records indicating that such record or copy is the original record or a copy thereof, made in the regular course of the business of the school, and that it was the regular course of such business to make such record at the time of the transactions, occurrences or events recorded therein or within a reasonable time thereafter. A subpoena directing production of such school or student records shall be served not less than eighteen hours before the time for production, provided such subpoena shall be valid if served less than eighteen hours before the time of production if written notice of intent to serve such subpoena has been delivered to the person in charge of such records not less than eighteen hours nor more than two weeks before such time for production.

Conn. Gen. Stat. § 10-154a (2007)

Professional communications between teacher or nurse and student.
Surrender of physical evidence obtained from students.

(a) As used in this section: (1) "School" means a public school as defined in section 10-183b or a private elementary or secondary school attendance at which meets the requirements of section 10-184; (2) a "professional employee" means a person employed by a school who (A) holds a certificate from the State Board of Education, (B) is a member of a faculty where certification is not required, (C) is an administration officer of a school, or (D) is a registered nurse employed by or assigned to a school; (3) a "student" is a person enrolled in a school; (4) a "professional communication" is any communication made privately and in confidence by a student to a professional employee of such student's school in the course of the latter's employment.

(b) Any such professional employee shall not be required to disclose any information acquired through a professional communication with a student, when such information concerns alcohol or drug abuse or any alcoholic or drug problem of such student but if such employee obtains physical evidence from such student indicating that a crime has been or is being committed by such student, such employee shall be required to turn such evidence over to school administrators or law enforcement officials within two school days after receipt of such physical evidence, provided if such evidence is obtained less than two days before a school vacation or the end of a school year, such evidence shall be turned over within two calendar days after receipt thereof, excluding Saturdays, Sundays and holidays, and

provided further in no such case shall such employee be required to disclose the name of the student from whom he obtained such evidence and such employee shall be immune from arrest and prosecution for the possession of such evidence obtained from such student.

(c) Any physical evidence surrendered to a school administration pursuant to subsection (b) of this section shall be turned over by such school administrator to the Commissioner of Consumer Protection or the appropriate law enforcement agency within three school days after receipt of such physical evidence, for its proper disposition, provided if such evidence is obtained less than three days before a school vacation or the end of a school year, such evidence shall be turned over within three calendar days from receipt thereof, excluding Saturdays, Sundays and holidays.

(d) Any such professional employee who, in good faith, discloses or does not disclose, such professional communication, shall be immune from any liability, civil or criminal, which might otherwise be incurred or imposed, and shall have the same immunity with respect to any judicial proceeding which results from such disclosure.

Conn. Gen. Stat. § 17a-75 (2007) (Formerly Sec. 17-205b)

Definitions.

For the purposes of sections 17a-75 to 17a-83, inclusive, the following terms shall have the following meanings: "Business day" means Monday through Friday except when a legal holiday falls thereon; "child" means any person less than sixteen years of age; "court" means the Superior Court-Juvenile Matters or the Court of Probate, unless either court is specifically stated; "hospital for mental illness of children" means any hospital, which provides, in whole or in part, diagnostic or treatment services for mental disorders of children, but shall not include any correctional institution of this state; "mental disorder" means a mental or emotional condition which has substantial adverse effects on a child's ability to function so as to jeopardize his or her health, safety or welfare or that of others, and specifically excludes mental retardation; "parent" means parent or legal guardian, including any guardian appointed under the provisions of subsection (i) of section 46b-129 or sections 45a-132, 45a-593 to 45a-597, inclusive, 45a-603 to 45a-622, inclusive, 45a-629 to 45a-638, inclusive, 45a-707 to 45a-709, inclusive, 45a-715 to 45a-718, inclusive, 45a-724 to 45a-737, inclusive, or 45a-743 to 45a-756, inclusive.

Conn. Gen. Stat. § 17a-79

Hospitalization of child for diagnosis or treatment of mental disorder.

(a) Except as provided in subsection (b) of this section, any hospital may admit any child for diagnosis or treatment of a mental disorder upon the written request of the child's parent. A child fourteen years of age or over may be admitted under this section without consent of his or her parents if such child consents in writing, provided that the parents of such child, if any, shall be notified within five days of such admission that such child has been hospitalized under the provisions of this subsection. If the whereabouts of such parents are unknown, then such child's nearest relative shall be so notified. In the event that a child's parent or guardian requests in writing release of such child, or in the event a child age fourteen or older who has been admitted with his or her written consent requests in writing his or her release, the hospital shall release such child or commence commitment proceedings in accordance with sections 17a-76 and 17a-77 and the hospital may detain the child for five business days, in order to allow an application to be filed. In the event such an application is filed, such hospitalization shall be continued for an additional period of time to allow such application to be heard, but in no event shall such hospitalization continue for more than fifteen days, or twenty-five days, if the matter has been transferred to the Superior Court, beyond the receipt of such application by the court.

(b) No child in the custody of the Commissioner of Children and Families shall be admitted for diagnosis or treatment except in accordance with sections 17a-76 to 17a-78, inclusive, unless (1) the commissioner requests such admission, (2) legal counsel appointed by the superior court for juvenile matters or court of probate in accordance with section 17a-76 agrees, in writing, to such admission, and (3) the child, if fourteen years of age or over consents to such admission. The parents or guardian of the person of such child, if any, shall be notified within five days of such admission that such child has been hospitalized under the provisions of this section. If the whereabouts of such parents or guardian of the person is unknown, then the nearest relative of such child shall be notified. In the event either parent or the guardian of the person of the child requests in writing the release of such child, the hospital shall release such child, unless the Commissioner of Children and Families commences commitment proceedings in accordance with sections 17a-76 and 17a-77. The hospital may detain the child for five business days after receipt of the written request in order to allow an application to be filed. If an application is filed, hospitalization shall be continued for an additional period of time to allow the application to be heard, but in no event shall hospitalization continue for more than fifteen days, or twenty-five days, if the matter has been transferred to the Superior Court, beyond the receipt of such application by the court.

Connecticut General Statutes

Conn. Gen. Stat. § 17a-81 (2007) (Formerly Sec. 17-205h)
Parental consent necessary for treatment.
Exceptions.

(a) Parental consent shall be necessary for treatment. In the event such consent is withheld or immediately unavailable and the physician concludes that treatment is necessary to prevent serious harm to the child, such emergency treatment may be administered pending receipt of parental consent.

(b) Involuntary patients may receive medication and treatment without their consent, or the consent of their parents, but no medical or surgical procedures may be performed without the written informed consent of: (1) The child's parent, if he or she has one; or (2) such child's next of kin; or (3) a qualified physician appointed by a judge of the Probate Court who signed the order of hospitalization, except in accordance with subsection (c) of this section.

(c) If the head of a hospital, in consultation with a physician, determines that the condition of a child, whether a voluntary or involuntary patient, is of an extremely critical nature, then emergency measures may be taken without the consent otherwise provided for in this section.

Conn. Gen. Stat. § 17a-101 (2007) (Formerly Sec. 17-38a)
Protection of children from abuse.
Mandated reporters.
Educational and training programs.

(a) The public policy of this state is: To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse, investigation of such reports by a social agency, and provision of services, where needed, to such child and family.

(b) The following persons shall be mandated reporters: Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, licensed practical nurse, medical examiner, dentist, dental hygienist, psychologist, coach of intramural or interscholastic athletics, school teacher, school principal, school guidance counselor, school paraprofessional, school coach, social worker, police officer, juvenile or adult probation officer, juvenile or adult parole officer, member of the clergy, pharmacist, physical therapist, optometrist, chiropractor, podiatrist, mental health professional or physician assistant, any person who is a licensed or certified emergency medical services provider, any person who is a licensed or certified alcohol and drug counselor, any person who is a licensed marital and family therapist, any person who is a sexual assault counselor or a battered women's counselor as defined in section 52-146k, any person who is a licensed professional counselor, any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home licensed by the state, any employee of the Department of Children and Families, any employee of the Department of Public Health who is responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps, the Child Advocate and any employee of the Office of Child Advocate.

(c) The Commissioner of Children and Families shall develop an educational training program for the accurate and prompt identification and reporting of child abuse and neglect. Such training program shall be made available to all persons mandated to report child abuse and neglect at various times and locations throughout the state as determined by the Commissioner of Children and Families.

(d) Any mandated reporter, as defined in subsection (b) of this section, who fails to report to the Commissioner of Children and Families pursuant to section 17a-101a shall be required to participate in an educational and training program established by the commissioner. The program may be provided by one or more private organizations approved by the commissioner, provided the entire costs of the program shall be paid from fees charged to the participants, the amount of which shall be subject to the approval of the commissioner.

Connecticut General Statutes

Conn. Gen. Stat. § 17a-101a (2007)

Report of abuse, neglect or injury of child or imminent risk of serious harm to child.
Penalty for failure to report.

Any mandated reporter, as defined in section 17a-101, who in the ordinary course of such person's employment or profession has reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, as defined in section 46b-120, (2) has had nonaccidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, shall report or cause a report to be made in accordance with the provisions of sections 17a-101b to 17a-101d, inclusive. Any person required to report under the provisions of this section who fails to make such report shall be fined not less than five hundred dollars nor more than two thousand five hundred dollars and shall be required to participate in an educational and training program pursuant to subsection (d) of section 17a-101.

Conn. Gen. Stat. § 17a-101b

Oral report by mandated reporter.
Notification of law enforcement agency when allegation of sexual abuse or serious physical abuse.
Notification of person in charge of institution, facility or school when staff member suspected of abuse or neglect.

(a) An oral report shall be made by a mandated reporter as soon as practicable but not later than twelve hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm, by telephone or in person to the Commissioner of Children and Families or a law enforcement agency. If a law enforcement agency receives an oral report, it shall immediately notify the Commissioner of Children and Families.

(b) If the commissioner or the commissioner's designee suspects or knows that such person has knowingly made a false report, the identity of such person shall be disclosed to the appropriate law enforcement agency and to the perpetrator of the alleged abuse.

(c) If the Commissioner of Children and Families, or the commissioner's designee, receives a report alleging sexual abuse or serious physical abuse, including, but not limited to, a report that: (1) A child has died; (2) a child has been sexually assaulted; (3) a child has suffered brain damage or loss or serious impairment of a bodily function or organ; (4) a child has been sexually exploited; or (5) a child has suffered serious nonaccidental physical injury, the commissioner shall, within twelve hours of receipt of such report, notify the appropriate law enforcement agency.

(d) Whenever a mandated reporter, as defined in section 17a-101, has reasonable cause to suspect or believe that any child has been abused or neglected by a member of the staff of a public or private institution or facility that provides care for such child or a public or private school, the mandated reporter shall report as required in subsection (a) of this section. The Commissioner of Children and Families or the commissioner's designee shall notify the person in charge of such institution, facility or school or the person's designee, unless such person is the alleged perpetrator of the abuse or neglect of such child. Such person in charge, or such person's designee, shall then immediately notify the child's parent or other person responsible for the child's care that a report has been made.

Conn. Gen. Stat. § 17a-101c (2007)

Written report by mandated reporter.

Within forty-eight hours of making an oral report, a mandated reporter shall submit a written report to the Commissioner of Children and Families or his representative. When a mandated reporter is a member of the staff of a public or private institution or facility that provides care for such child or public or private school he shall also submit a copy of the written report to the person in charge of such institution, school or facility or the person's designee. In the case of a report concerning a school employee holding a certificate, authorization or permit issued by the State Board of Education under the provisions of sections 10-144o to 10-146b, inclusive, and 10- 149, a copy of the written report shall also be sent by the person in charge of such institution, school or facility to the Commissioner of Education or his representative. In the case of an employee of a facility or institution that provides care for a child which is licensed by the state, a copy of the written report shall also be sent by the mandated reporter to the executive head of the state licensing agency.

Connecticut General Statutes

Conn. Gen. Stat. § 17a-101g (2007)
Classification and evaluation of reports.
Determination of abuse or neglect of child.
Investigation.
Notice, entry of recommended finding.
Referral to local law enforcement authority.
Home visit.
Removal of child in imminent risk of harm.

(a) Upon receiving a report of child abuse or neglect, as provided in sections 17a-101a to 17a-101c, inclusive, or section 17a-103, in which the alleged perpetrator is (1) a person responsible for such child's health, welfare or care, (2) a person given access to such child by such responsible person, or (3) a person entrusted with the care of a child, the Commissioner of Children and Families, or the commissioner's designee, shall cause the report to be classified and evaluated immediately. If the report contains sufficient information to warrant an investigation, the commissioner shall make the commissioner's best efforts to commence an investigation of a report concerning an imminent risk of physical harm to a child or other emergency within two hours of receipt of the report and shall commence an investigation of all other reports within seventy-two hours of receipt of the report. The department shall complete any such investigation not later than forty-five calendar days after the date of receipt of the report. If the report is a report of child abuse or neglect in which the alleged perpetrator is not a person specified in subdivision (1), (2) or (3) of this subsection, the Commissioner of Children and Families shall refer the report to the appropriate local law enforcement authority for the town in which the child resides or in which the alleged abuse or neglect occurred.

(b) The investigation shall include a home visit at which the child and any siblings are observed, if appropriate, a determination of the nature, extent and cause or causes of the reported abuse or neglect, a determination of the person or persons suspected to be responsible for such abuse or neglect, the name, age and condition of other children residing in the same household and an evaluation of the parents and the home. The report of such investigation shall be in writing. The investigation shall also include, but not be limited to, a review of criminal conviction information concerning the person or persons alleged to be responsible for such abuse or neglect and previous allegations of abuse or neglect relating to the child or other children residing in the household or relating to family violence. After an investigation into a report of abuse or neglect has been completed, the commissioner shall determine, based upon a standard of reasonable cause, whether a child has been abused or neglected, as defined in section 46b-120. If the commissioner determines that abuse or neglect has occurred, the commissioner shall also determine whether: (1) There is an identifiable person responsible for such abuse or neglect; and (2) such identifiable person poses a risk to the health, safety or well-being of children and should be recommended by the commissioner for placement on the child abuse and neglect registry established pursuant to section 17a-101k. If the commissioner has made the determinations in subdivisions (1) and (2) of this subsection, the commissioner shall issue notice of a recommended finding to the person suspected to be responsible for such abuse or neglect in accordance with section 17a-101k.

(c) Except as provided in subsection (d) of this section, no entry of the recommended finding shall be made on the child abuse or neglect registry and no information concerning the finding shall be disclosed by the commissioner pursuant to a check of the child abuse or neglect registry or request for information by a public or private entity for employment, licensure, or reimbursement for child care purposes pursuant to programs administered by the Department of Social Services or pursuant to any other general statute that requires a check of the child abuse or neglect registry until the exhaustion or waiver of all administrative appeals available to the person suspected to be responsible for the abuse or neglect, as provided in section 17a-101k.

(d) If the child abuse or neglect resulted in or involves (1) the death of a child; (2) the risk of serious physical injury or emotional harm of a child; (3) the serious physical harm of a child; (4) the arrest of a person due to abuse or neglect of a child; (5) a petition filed by the commissioner pursuant to section 17a-112 or 46b-129; or (6) sexual abuse of a child, entry of the recommended finding may be made on the child abuse or neglect registry and information concerning the finding may be disclosed by the commissioner pursuant to a check of the child abuse or neglect registry or request for information by a public or private entity for employment, licensure, or reimbursement for child care purposes pursuant to programs administered by the Department of Social Services or pursuant to any other general statute that requires a check of the child abuse or neglect registry, prior to the exhaustion or waiver of all administrative appeals available to the person suspected to be responsible for the abuse or neglect as provided in section 17a-101k.

(e) If the Commissioner of Children and Families, or the commissioner's designee, has probable cause to believe that the child or any other child in the household is in imminent risk of physical harm from the child's surroundings and that immediate removal from such surroundings is necessary to ensure the child's safety, the commissioner, or the commissioner's designee, shall authorize any employee of the department or any law enforcement officer to remove the child and any other child similarly situated from such surroundings without the

consent of the child's parent or guardian. The commissioner shall record in writing the reasons for such removal and include such record with the report of the investigation conducted under subsection (b) of this section.

(f) The removal of a child pursuant to subsection (e) of this section shall not exceed ninety-six hours. During the period of such removal, the commissioner, or the commissioner's designee, shall provide the child with all necessary care, including medical care, which may include an examination by a physician or mental health professional with or without the consent of the child's parents, guardian or other person responsible for the child's care, provided reasonable attempts have been made to obtain consent of the child's parents or guardian or other person responsible for the care of such child. During the course of a medical examination, a physician may perform diagnostic tests and procedures necessary for the detection of child abuse or neglect. If the child is not returned home within such ninety-six-hour period, with or without protective services, the department shall proceed in accordance with section 46b-129.

Conn. Gen. Stat. § 17a-504 (2007) (Formerly Sec. 17-184)

Penalty for wrongful acts re the commitment or psychiatric disabilities of another person.

Any person who willfully and maliciously causes, or attempts to cause, or who conspires with any other person to cause, any person who does not have psychiatric disabilities to be committed to any hospital for psychiatric disabilities, and any person who wilfully certifies falsely to the psychiatric disabilities of any person in any certificate provided for in sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, 17a-495 to 17a-528, inclusive, 17a-540 to 17a-550, inclusive, 17a-560 to 17a-576, inclusive, and 17a-615 to 17a-618, inclusive, and any person who, under the provisions of said sections relating to persons with psychiatric disabilities, wilfully reports falsely to any court or judge that any person has psychiatric disabilities, shall be fined not more than one thousand dollars or imprisoned not more than five years or both.

Conn. Gen. Stat. § 17a-540 (2007) (Formerly Sec. 17-206a)

Definitions.

As used in sections 17a-540 to 17a-550, inclusive, unless otherwise expressly stated or unless the context otherwise requires:

(1) "**Facility**" means any inpatient or outpatient hospital, clinic or other facility for the diagnosis, observation or treatment of persons with psychiatric disabilities;

(2) "**Patient**" means any person being treated in a facility;

(3) "**Persons with psychiatric disabilities**" means those children and adults who are suffering from one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders";

(4) "**Voluntary patient"** means any patient sixteen years of age or older who applies in writing for and is admitted to a hospital for observation, diagnosis or treatment of a mental disorder or any patient under sixteen years of age whose parent or legal guardian applies in writing for such observation, diagnosis or treatment;

(5) "**Involuntary patient**" means any patient hospitalized pursuant to an order of a judge of the Probate Court after an appropriate hearing or a patient hospitalized for emergency diagnosis, observation or treatment upon certification of a qualified physician;

(6) "**Family**" means spouse or next of kin;

(7) "**Head of the hospital**" or "**head of the facility**" means the superintendent or medical director of a hospital or facility, or his designated delegate;

(8) "**Informed consent**" means permission given competently and voluntarily after a patient has been informed of the reason for treatment, the nature of the proposed treatment, the advantages or disadvantages of the treatment, medically acceptable alternative treatment, the risks associated with receiving the proposed treatment and the risk of no treatment;

(9) "**Medically harmful**" means capable of inflicting serious mental or physical injury on the patient, or producing in the patient a disturbed mental state or impaired judgment which may be grossly detrimental to his physical or mental well being;

(10) "**Psychosurgery**" means those operations defined as lobotomy, psychiatric surgery, behavioral surgery and all other forms of brain surgery, if the surgery is performed for

the purpose of modification or control of thoughts, feelings, actions or behavior rather than the treatment of a known and diagnosed physical disease of the brain;

(11) "**Shock therapy**" means a form of psychiatric treatment in which electric current, insulin, carbon dioxide or indoklon, or other similar agent, is administered to the patient and results in a loss of consciousness or a convulsive or comatose reaction;

(12) "**Direct threat of harm**" means that the patient's clinical history demonstrates a pattern of serious physical injury or life-threatening injury to self or to others which is caused by the psychiatric disabilities with which the patient has been diagnosed and is documented by objective medical and other factual evidence. Such evidence of past pattern of dangerous behavior shall be manifested in the patient's medical history and there shall exist a high probability that the patient will inflict substantial harm on himself or others; and

(13) "**Special limited conservator**" means a licensed health care provider with specialized training in the treatment of persons with psychiatric disabilities appointed by a judge of the Probate Court with specific authority to consent to the administration of medication to a defendant during the pendency of such defendant's placement in the custody of the Commissioner of Mental Health and Addiction Services pursuant to section 54-56d. Upon the termination of the patient's placement in the custody of the commissioner pursuant to section 54-56d, the special limited conservatorship shall automatically terminate.

Conn. Gen. Stat. § 17a-541 (2007) (Formerly Sec. 17-206b)

Deprivation of rights of patient prohibited. Exception.

No patient hospitalized or treated in any public or private facility for the treatment of persons with psychiatric disabilities shall be deprived of any personal, property or civil rights, including the right to vote, hold or convey property, and enter into contracts, except in accordance with due process of law, and unless such patient has been declared incapable pursuant to sections 45a-644 to 45a-662, inclusive. Any finding of incapability shall specifically state which civil or personal rights the patient is incapable of exercising.

Conn. Gen. Stat. § 17a-542 (2007) (Formerly Sec. 17-206c)

Humane and dignified treatment required. Formulation of discharge plan.

Every patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder. Such treatment plan shall include a discharge plan which shall include, but not be limited to, (1) reasonable notice to the patient of his impending discharge, (2) active participation by the patient in planning for his discharge and (3) planning for appropriate aftercare to the patient upon his discharge.

Conn. Gen. Stat. § 17a-543 (2007) (Effective Oct. 1, 2007)

Procedures governing medication, treatment, psychosurgery and shock therapy.

(a) No patient shall receive medication for the treatment of the psychiatric disabilities of such patient without the informed consent of such patient, except in accordance with procedures set forth in subsections (b), (d), (e) and (f) of this section or in accordance with section 17a-543a, 17a-566 or 54- 56d.

(b) No medical or surgical procedures may be performed without the patient's written informed consent or, if the patient has been declared incapable of caring for himself or herself pursuant to sections 45a-644 to 45a-662, inclusive, and a conservator of the person has been appointed pursuant to section 45a-650, the written consent of such conservator. If the head of the hospital, in consultation with a physician, determines that the condition of an involuntary patient not declared incapable of caring for himself or herself pursuant to said sections is of an extremely critical nature and the patient is incapable of informed consent, medical or surgical procedures may be performed with the written informed consent of: (1) The patient's health care representative; (2) the patient's conservator or guardian, if he or she has one; (3) the patient's next of kin; (4) a person designated by the patient pursuant to section 1-56r; or (5) a qualified physician appointed by a judge of the Probate Court. Notwithstanding the provisions of this section, if obtaining the consent provided for in this section would cause a medically harmful delay to a voluntary or involuntary patient whose condition is of an extremely critical nature, as determined by personal observation by a physician or the senior clinician on duty, emergency treatment may be provided without consent.

(c) No psychosurgery or shock therapy shall be administered to any patient without the patient's written informed consent, except as provided in this subsection. Such consent shall be for a maximum period of thirty days and may be revoked at any time. If it is determined by the head of the hospital and two qualified physicians that the patient has become incapable of giving informed consent, shock therapy may be administered upon order of the Probate Court if, after hearing, such court finds that the patient is incapable of informed consent and there is no other, less intrusive beneficial treatment. An order of the Probate Court authorizing the administration of shock therapy pursuant to this subsection shall be effective for not more than forty-five days.

(d) A facility may establish an internal procedure governing decisions concerning involuntary medication treatment for inpatients. Such procedure shall provide (1) that any decision concerning involuntary medication treatment shall be made by a person who is not employed by the facility in which the patient is receiving treatment, provided the selection of such person shall not be made until the patient's advocate has had reasonable opportunity to discuss such selection with the facility, (2) written and oral notification to the patient of available advocacy services, (3) notice to the patient and the patient's advocate, if one has been chosen, of any proceeding for the determination of the necessity for involuntary treatment not less than forty-eight hours prior to such proceeding, (4) the right of the patient to representation during any such proceeding, (5) questioning of any witness at any such proceeding including, if requested, one or both of the physicians who made the determination pursuant to subsection (e) of this section concerning the patient's capacity to give informed consent and the necessity of medication for the patient's treatment, and (6) a written decision. If a decision is made in accordance with the standards set forth in this section that a patient shall receive involuntary medication, and there is substantial probability that without such medication for the treatment of the psychiatric disabilities of the patient the condition of the patient will rapidly deteriorate, such involuntary medication may be provided for a period not to exceed thirty days or until a decision is made by the Probate Court under subsection (e) or (f) of this section, whichever is sooner.

(e)(1)(A) If it is determined by the head of the hospital and two qualified physicians that a patient is incapable of giving informed consent to medication for the treatment of the patient's psychiatric disabilities and such medication is deemed to be necessary for the patient's treatment, a facility may utilize the procedures established in subsection (d) of this section and may apply to the Probate Court for appointment of a conservator of the person with specific authority to consent to the administration of medication or, in a case where a conservator of the person has previously been appointed under section 45a-650, the facility or the conservator may petition the Probate Court to grant such specific authority to the conservator. The Probate Court may appoint a conservator with such specific authority pursuant to this subparagraph if the court finds by clear and convincing evidence that the patient is incapable of giving informed consent to medication for the treatment of the patient's psychiatric disability and such medication is necessary for the patient's treatment.
(B) The conservator shall meet with the patient and the physician, review the patient's written record and consider the risks and benefits from the medication, the likelihood and seriousness of adverse side effects, the preferences of the patient, the patient's religious views, and the prognosis with and without medication. After consideration of such information, the conservator shall either consent to the patient receiving medication for the treatment of the patient's psychiatric disabilities or refuse to consent to the patient receiving such medication.
(2) The authority of a conservator to consent to the administration of medication under subdivision (1) of this subsection shall be effective for not more than one hundred twenty days. In the case of continuous hospitalization of the patient beyond such one hundred twenty days, if the head of the hospital and two qualified physicians determine that the patient continues to be incapable of giving informed consent to medication for the treatment of the patient's psychiatric disabilities and such medication is deemed to be necessary for the patient's treatment, the authority of the conservator to consent to the administration of medication may be extended for a period not to exceed one hundred twenty days by order of the Probate Court without a hearing upon application by the head of the hospital. Prompt notice of the order shall be given to the patient, conservator and facility.

(f)(1) If it is determined by the head of the hospital and two qualified physicians that (A) a patient is capable of giving informed consent but refuses to consent to medication for treatment of the patient's psychiatric disabilities, (B) there is no less intrusive beneficial treatment, and (C) without medication, the psychiatric disabilities with which the patient has been diagnosed will continue unabated and place the patient or others in direct threat of harm, the facility may utilize the procedures established in subsection (d) of this section and may apply to the Probate Court to authorize the administration to the patient of medication for the treatment of the patient's psychiatric disabilities, despite the refusal of the patient to consent to such medication. The Probate Court may authorize the administration of medication to the patient pursuant to this subdivision if the court finds by clear and convincing evidence that (i) the patient is capable of giving informed consent but refuses to consent to medication for treatment of the patient's psychiatric disabilities, (ii) there is no less intrusive beneficial treatment, and (iii) without

medication, the psychiatric disabilities with which the patient has been diagnosed will continue unabated and place the patient or others in direct threat of harm.
(2) An order authorizing the administration of medication under subdivision (1) of this subsection shall be effective for not more than one hundred twenty days. In the case of continuous hospitalization of the patient beyond such one hundred twenty days, if the head of the hospital and two qualified physicians determine that (A) the patient continues to be capable of giving informed consent but refuses to consent to medication for treatment of the patient's psychiatric disabilities, (B) there is no less intrusive beneficial treatment, and (C) without medication, the psychiatric disabilities with which the patient has been diagnosed will continue unabated and place the patient or others in direct threat of harm, the order may be extended for a period not to exceed one hundred twenty days by order of the Probate Court without a hearing. Prompt notice of the order shall be given to the patient and facility.

(g) If a decision has been made to administer involuntary medication to a patient pursuant to subsection (d) of this section, the patient may petition the Probate Court to expedite the hearing on an application filed by the facility pursuant to subsection (e) or (f) of this section or, if no application has been filed, to hold a hearing to decide whether to allow the administration of involuntary medication. Either hearing shall be held within fifteen days after the date of the patient's petition.

(h) For the purposes of this section, "voluntary patient" means any patient sixteen years of age or older who applies in writing for, and is admitted to, a hospital for observation, diagnosis or treatment of a mental disorder.

(i) Unless there is a serious risk of harm to the patient or others, based upon the patient's past history or current condition, nothing in this section authorizes any form of involuntary medical, psychological or psychiatric treatment of any patient who in the sincere practice of his or her religious beliefs is being treated by prayer alone in accordance with the principles and practices of a church or religious denomination by a duly accredited practitioner or ordained minister, priest or rabbi thereof. The Department of Mental Health and Addiction Services shall adopt regulations, in accordance with chapter 54, [FN1] to implement the purposes of this subsection.

[FN1] C.G.S.A. § 4-166 et seq

Conn. Gen. Stat. § 17a-544 (2007) (Formerly Sec. 17-206e)

Placement of patient in seclusion or mechanical restraint. Medication not to be used as substitute for habilitation.

(a) No patient may be placed involuntarily in seclusion or a mechanical restraint unless necessary because there is imminent physical danger to the patient or others and a physician so orders. A written memorandum of such order, and the reasons therefor, shall be placed in the patient's permanent clinical record within twenty-four hours.

(b) Medication shall not be used as a substitute for an habilitation program.

Conn. Gen. Stat. § 17a-545 (2007) (Formerly Sec. 17-206f)

Physical and psychiatric examinations.

Every patient hospitalized under any of sections 17a-540 to 17a-550, inclusive, shall receive a physical examination within five days of his hospitalization, and at least once each year thereafter. Every patient shall be examined by a psychiatrist within forty-eight hours of his hospitalization, and at least once each six months thereafter. Reports of all physical and psychiatric examinations shall be completed and signed by the examining physicians and made a part of the patient's permanent clinical record.

Conn. Gen. Stat. § 17a-546 (2007) (Formerly Sec. 17-206g)

Communication by mail and telephone.

(a) Every patient shall be permitted to communicate by sealed mail with any individual, group or agency, except as herein provided.

(b) Every hospital for treatment of persons with psychiatric disabilities shall furnish writing materials and postage to any patient desiring them.

(c) If the head of the hospital or his authorized representative receives a complaint from a person demonstrating that such person is receiving threatening or harassing mail from a patient, the head of the hospital or his authorized representative may, after providing a reasonable opportunity for the patient to respond to the complaint, restrict such patient's mail to the complainant. The head of the hospital or his authorized representative shall notify the patient of the availability of advocacy services if such patient's mailing rights are restricted. Any such restriction shall be noted in writing, signed by the head of the hospital, and made a part of the patient's permanent clinical record.

(d) If the head of the hospital or his authorized representative determines that it is medically harmful to a patient to receive mail, all such correspondence shall be returned unopened to the sender, with an explanation, signed by the head of the hospital, for its return. A copy of this explanation shall be made a part of the patient's permanent clinical record.

(e) Every patient shall be permitted to make and receive telephone calls, except as herein provided. Public telephones shall be made available in appropriate locations.

(f) If the head of the hospital or his authorized representative determines that a patient has made obscene or threatening telephone calls, he may restrict such patient's right to make telephone calls. Any such restriction shall be noted in writing, signed by the head of the hospital, and made a part of the patient's permanent clinical record.

(g) If the head of the hospital or his authorized representative determines that it is medically harmful to a patient to make or receive telephone calls, this fact shall be explained, in writing, signed by the head of the hospital, to the patient's family and any persons who regularly make calls to, or receive calls from, the patient. A copy of the explanation shall be signed by the head of the hospital and placed in the patient's permanent clinical record.

Conn. Gen. Stat. § 17a-547 (2007) (Formerly Sec. 17-206h)

Visitors.
Restrictions on mail, telephone and visitor privileges, when allowed.

(a) Every patient shall be permitted to receive visitors at regular visiting hours, except as herein provided. The head of the hospital shall: (1) Establish visiting hours, and inform all patients and their families and other visitors of these hours; and (2) designate the areas of the hospital where a patient may receive visitors, and inform all patients and their families and other visitors of these areas.

(b) If, because of extenuating circumstances, a patient's family cannot visit during the regular visiting hours, the head of the hospital shall designate one two-hour period per week, at a mutually convenient time, during which the patient's family may visit the patient.

(c) A patient's clergyman, lawyer or physician may visit the patient at any reasonable time.

(d) If the head of the hospital determines that it is medically harmful for the patient to receive visitors, he shall so inform the patient's family and other visitors. When the patient has recovered sufficiently to receive visitors, the head of the hospital shall immediately notify the patient's family and other visitors who have requested notification. A copy of the notification of any restriction of visitors, and the reasons therefor, shall be signed by the head of the hospital and placed in the patient's permanent clinical record.

(e) The provisions of this section shall not apply to any patient in a program or facility for the treatment of drug-dependent persons.

(f) No restriction of any patient's rights to send and receive mail, make and receive telephone calls, or receive visitors shall be made in any manner, or for any reasons, other than prescribed in section 17a-546 and this section.

Conn. Gen. Stat. § 17a-548 (2007) (Formerly Sec. 17-206i)

Patient's rights re clothing, possessions, money and access to records.
List of rights to be posted.

(a) Any patient shall be permitted to wear his or her own clothes; to keep and use personal possessions including toilet articles; except for patients hospitalized in Whiting Forensic Division; to be present during any search of his personal possessions; to have access to individual storage space for such possessions; and in such manner as determined by the facility to spend a reasonable sum of his or her own money for canteen expenses and small purchases. These rights shall be denied only if the superintendent, director, or his authorized representative determines that it is medically harmful to the patient to exercise such rights. An explanation of such denial shall be placed in the patient's permanent clinical record.

(b) In connection with any litigation related to hospitalization, or at any time following discharge from the facility, any patient or his or her attorney shall have the right, upon written request, to inspect all of such patient's hospital records, and to make copies thereof. Unless the request is made in connection with any litigation related to hospitalization, a mental health facility, as defined in subdivision (5) of section 52-146d, may refuse to disclose any portion of a patient's record which the mental health facility determines: (1) Would create a substantial risk that the patient would inflict life-threatening injury to self or to others or experience a severe deterioration in mental state; (2) would constitute an invasion of privacy of another person; or (3) would violate an assurance of confidentiality furnished to another person, provided only such portion of the record the disclosure of which would not constitute an invasion of privacy of another person or violate an assurance of confidentiality furnished to another person shall be

disclosed. Any patient aggrieved by a facility's refusal to disclose under this subsection may petition the Superior Court for relief in the same manner as a patient proceeding under section 4-105, except that in addition to notice and a hearing, the court may conduct an in camera review of the record. The court shall order disclosure of the record by such facility unless the court determines that the disclosure (A) would create a substantial risk that the patient would inflict life-threatening injury to self or to others or experience a severe deterioration in mental state, or (B) would constitute an invasion of privacy of another person, or (C) would violate an assurance of confidentiality furnished to another person, provided if the court orders disclosure of the record, only such portion of the record the disclosure of which would not constitute an invasion of privacy of another person or violate an assurance of confidentiality furnished to another person shall be disclosed.

(c) A list of all in-hospital rights shall be prominently posted in each ward where mental health services are provided. Such list shall include, but not be limited to, the right to leave, as afforded by subsection (a) of section 17a-506, the right to a hearing, as afforded by subsection (d) of section 17a-502, and the right to file a complaint, as afforded by the hospital's complaint procedure.

(d) Nothing in subsection (b) of this section shall limit a patient's right of access to his records under section 4-104.

Conn. Gen. Stat. § 17a-549 (2007) (Formerly Sec. 17-206j)

Denial of employment, housing, licenses, because of history of mental disorder restricted.

(a) No person shall be denied employment, housing, civil service rank, any license or permit, including a professional license, or any other civil or legal right, solely because of a present or past history of mental disorder, except as so provided by the general statutes.

(b) The burden shall be on the person or agency denying any such right to prove that the person so denied is not suitable solely because of his present or past history of mental disorder.

Conn. Gen. Stat. § 17a-550 (2007) (Formerly Sec. 17-206k)

Remedies of aggrieved persons.

Any person aggrieved by a violation of sections 17a-540 to 17a-549, inclusive, may petition the superior court within whose jurisdiction the person is or resides for appropriate relief, including temporary and permanent injunctions, or may bring a civil action for damages.

Conn. Gen. Stat. § 17a-688 (2007) (Formerly Sec.19a-126h)

Records, keeping and confidentiality of.
Disclosure permitted, when.
Minors, consent to treatment and liability for costs.

(a) All records maintained by the court of cases coming before it under the provisions of sections 17a-465a, 17a-673 and 17a-680 to 17a-690, inclusive, shall be sealed and available only to the respondent or the respondent's counsel unless the court, after hearing held with notice to the respondent, determines such record should be disclosed for cause shown.

(b) Medical treatment facilities shall keep and submit such records of all persons examined, admitted or treated pursuant to sections 17a-465a, 17a-673 and 17a-680 to 17a-690, inclusive, as may be required by the department.

(c) No person, hospital or treatment facility may disclose or permit the disclosure of, nor may the department disclose or permit the disclosure of, the identity, diagnosis, prognosis or treatment of any such patient that would constitute a violation of federal statutes concerning confidentiality of alcohol or drug patient records and any regulations pursuant thereto, as such federal statutes and regulations may be amended from time to time. The department shall adopt regulations, in accordance with chapter 54, to protect the confidentiality of any such information that is obtained by the department.

(d) If the person seeking treatment or rehabilitation for alcohol dependence or drug dependence is a minor, the fact that the minor sought such treatment or rehabilitation or that the minor is receiving such treatment or rehabilitation, shall not be reported or disclosed to the parents or legal guardian of the minor without the minor's consent. The minor may give legal consent to receipt of such treatment and rehabilitation. A minor shall be personally liable for all costs and expenses for alcohol and drug dependency treatment afforded to the minor at the minor's request under section 17a-682.

(e) The commissioner may use or make available to authorized persons information from patients' records for purposes of conducting scientific research, management

audits, financial audits or program evaluation, provided such information shall not be utilized in a manner that discloses a patient's name or other identifying information.

Conn. Gen. Stat. § 19a-7d (2007)
Primary care direct services program.

(a) The Commissioner of Public Health may establish, within available appropriations, a program to provide three-year grants to community-based providers of primary care services in order to expand access to health care for the uninsured. The grants may be awarded to community-based providers of primary care for (1) funding for direct services, (2) recruitment and retention of primary care clinicians and registered nurses through subsidizing of salaries or through a loan repayment program, and (3) capital expenditures. The community-based providers of primary care under the direct service program shall provide, or arrange access to, primary and preventive services, referrals to specialty services, including rehabilitative and mental health services, inpatient care, prescription drugs, basic diagnostic laboratory services, health education and outreach to alert people to the availability of services. Primary care clinicians and registered nurses participating in the state loan repayment program or receiving subsidies shall provide services to the uninsured based on a sliding fee schedule, provide free care if necessary, accept Medicare assignment and participate as a Medicaid provider, or provide nursing services in school-based health centers. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, [FN1] to establish eligibility criteria, services to be provided by participants, the sliding fee schedule, reporting requirements and the loan repayment program. For the purposes of this section, "primary care clinicians" includes family practice physicians, general practice osteopaths, obstetricians and gynecologists, internal medicine physicians, pediatricians, dentists, certified nurse midwives, advanced practice registered nurses, physician assistants and dental hygienists.

(b) Funds appropriated for the state loan repayment program shall not lapse until fifteen months following the end of the fiscal year for which such funds were appropriated.

Conn. Gen. Stat. § 19a-7h (2007)
Childhood immunization registry. Regulations.

(a) The Commissioner of Public Health or his designee may, within the limitations of available resources, establish and maintain for the purpose of assuring timely childhood immunization an ongoing registry of all children who have not begun the first grade of school including all newborns. The registry shall include such information as is necessary to accurately identify a child and to assess current immunization status.

(b) For purposes of this section, "health care provider" means a person who has direct or supervisory responsibility for the delivery of immunization including licensed physicians, nurse practitioners, nurse midwives, physician assistants and nurses. Each health care provider who has provided health care to a child listed in the registry shall report to the commissioner or his designee sufficient information to identify the child and the name and date of each vaccine dose given to that child or when appropriate, contraindications or exemptions to administration of each vaccine dose. Reports shall be made by such means determined by the commissioner to result in timely reporting. Each health care provider intending to administer vaccines to any child listed on the registry and each parent or guardian of such child shall be provided current information as contained in the registry on the immunization status of the child for the purposes of determining whether additional doses of recommended routine childhood immunizations are needed, or to officially document immunization status to meet state day care or school immunization entry requirements pursuant to sections 10-204a, 19a-79 and 19a-87b and regulations adopted thereunder. Each director of health of any town, city or health district shall be provided with sufficient information on the children who live in his jurisdiction and who are listed on the registry to enable determination of which children are overdue for scheduled immunizations and to enable provision of outreach to assist in getting each such child vaccinated.

(c) Except as specified in subsections (a) and (b) of this section, all personal information including vaccination status and dates of vaccination of individuals shall be confidential pursuant to section 19a-25 and shall not be further disclosed without the authorization of the child or the child's legal guardian. After consultation with the state Childhood Immunization Advisory Council established under section 19a-7g, the commissioner shall adopt regulations, pursuant to chapter 54, to specify how information on vaccinations or exemptions from vaccination will be reported in a timely manner to the registry, how information on the registry will be made available to health care providers, parents or guardians, and directors of health, how parents or guardians may decline their child's enrollment in the registry, and to otherwise implement the provisions of this section.

Connecticut General Statutes

Conn. Gen. Stat. § 19a-14c (2007)
Provision of outpatient mental health treatment to minors without parental consent.

(a) For the purposes of this section, "outpatient mental health treatment" means the treatment of mental disorders, emotional problems or maladjustments with the object of (1) removing, modifying or retarding existing symptoms; (2) improving disturbed patterns of behavior; and (3) promoting positive personality growth and development. Treatment shall not include prescribing or otherwise dispensing any medication which is a legend drug as defined in section 20-571.

(b) A psychiatrist licensed pursuant to chapter 370, a psychologist licensed pursuant to chapter 383, an independent social worker certified pursuant to chapter 383b or a marital and family therapist licensed pursuant to chapter 383a may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor if (1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively. The provider of such treatment shall document the reasons for any determination made to treat a minor without the consent or notification of a parent or guardian and shall include such documentation in the minor's clinical record, along with a written statement signed by the minor stating that (A) he is voluntarily seeking such treatment; (B) he has discussed with the provider the possibility of involving his parent or guardian in the decision to pursue such treatment; (C) he has determined it is not in his best interest to involve his parent or guardian in such decision; and (D) he has been given adequate opportunity to ask the provider questions about the course of his treatment.

(c) After the sixth session of outpatient mental health treatment provided to a minor pursuant to this section, the provider of such treatment shall notify the minor that the consent, notification or involvement of a parent or guardian is required to continue treatment, unless such a requirement would be seriously detrimental to the minor's well-being. If the provider determines such a requirement would be seriously detrimental to the minor's well-being, he shall document such determination in the minor's clinical record, review such determination every sixth session thereafter and document each such review. If the provider determines such a requirement would no longer be seriously detrimental to the minor's well-being, he shall require the consent, notification or involvement of a parent or guardian as a condition of continuing treatment. No provider shall notify a parent or guardian of treatment provided pursuant to this section or disclose any information concerning such treatment to a parent or guardian without the consent of the minor.

(d) A parent or guardian who is not informed of the provision of outpatient mental health treatment for his minor child pursuant to this section shall not be liable for the costs of the treatment provided.

Conn. Gen. Stat. § 19a-215 (2007) (Formerly Sec. 19-89)
Reports of diseases on the commissioner's list of reportable diseases and laboratory findings.
Confidentiality.
Fines.

(a) For the purposes of this section:

(1) "Commissioner's list of reportable diseases and laboratory findings" means the list developed pursuant to section 19a-2a.

(2) "Confidential" means confidentiality of information pursuant to section 19a-25.

(3) "Health care provider" means a person who has direct or supervisory responsibility for the delivery of health care or medical services, including licensed physicians, nurse practitioners, nurse midwives, physician assistants, nurses, dentists, medical examiners and administrators, superintendents and managers of health care facilities.

(b) Each health care provider shall report in writing or by telephone each case occurring in his practice, of any disease on the commissioner's list of reportable diseases and laboratory findings to the director of health of the town, city or borough in which such case resides and to the Department of Public Health, within twelve hours after his recognition of the disease. Such reports of disease shall be confidential and not open to public inspection except as provided in subsection (d) of this section.

(c) When a local director of health or his authorized agent or the Department of Public Health receives a report of a disease or laboratory finding on the commissioner's list of reportable disease and laboratory findings, either may contact first the reporting health care provider and then the person with the reportable finding to obtain such information as may be necessary to lead to the effective control of further spread of such disease. In the case of reportable communicable diseases and laboratory findings, this

information may include obtaining the identification of persons who may be the source or subsequent contacts of such infection.

(d) All personal information obtained from disease prevention and control investigations as performed in subsection (c) of this section including the health care provider's name and the identity of the reported case of disease and suspected source persons and contacts shall not be divulged to anyone and shall be held strictly confidential pursuant to section 19a-25, by the local director of health and his authorized agent and by the Department of Public Health.

(e) Any person who violates any reporting or confidentiality provision of this section shall be fined not more than five hundred dollars. No provision of this section shall be deemed to supersede section 19a-584.

Conn. Gen. Stat. § 19a-216 (2007) (Formerly Sec. 19-89a)

Examination and treatment of minor for venereal disease. Confidentiality. Liability for costs.

(a) Any municipal health department, state institution or facility, licensed physician or public or private hospital or clinic, may examine and provide treatment for venereal disease for a minor, if the physician or facility is qualified to provide such examination and treatment. The consent of the parents or guardian of the minor shall not be a prerequisite to the examination and treatment. The physician in charge or other appropriate authority of the facility or the licensed physician concerned shall prescribe an appropriate course of treatment for the minor. The fact of consultation, examination and treatment of a minor under the provisions of this section shall be confidential and shall not be divulged by the facility or physician, including the sending of a bill for the services to any person other than the minor, except for purposes of reports under section 19a-215, and except that, if the minor is not more than twelve years of age, the facility or physician shall report the name, age and address of that minor to the Commissioner of Children and Families or his designee who shall proceed thereon as in reports under section 17a-101g.

(b) A minor shall be personally liable for all costs and expenses for services afforded him at his request under this section.

Conn. Gen. Stat. § 19a-582 (2007)

Informed consent for testing. Exceptions.

(a) Except as required pursuant to section 19a-586 or by federal or state law, no person shall order the performance of an HIV-related test without first receiving written informed consent or oral informed consent which has been documented in the medical record, of the subject of the test or of a person authorized to consent to health care for such individual. The consent of a parent or guardian shall not be a prerequisite to testing of a minor. The laboratory shall report the test result to the person who orders the performance of the test. Whenever practicable written consent shall be obtained. A person ordering the performance of an HIV-related test shall certify that informed consent has been received prior to ordering testing by a licensed laboratory. No laboratory shall perform an HIV-related test without a written certification that such consent has been obtained, or without written certification that testing without consent is being ordered pursuant to one of the exceptions in subsection (e) of this section. The Department of Public Health shall develop recommended forms for health care providers for purposes of this section. Such forms shall satisfy the requirement for a written consent form but shall not fully satisfy the requirement for the explanation pursuant to subsections (b) and (c) of this section. Any form used pursuant to this section and all information conveyed pursuant to subsections (c) and (d) of this section shall be written or conveyed in a clear and coherent manner using plain language as described in section 42-152. A person ordering the performance of an HIV-related test shall not be held liable if a good faith effort is made to convey the explanation required pursuant to subsections (b), (c) and (d) of this section. The department shall develop guidelines for meeting the requirements of subsections (b), (c) and (d) of this section.

(b) Informed consent to an HIV-related test shall include a statement provided to the subject of the test or provided to a person authorized to consent to health care for the subject which includes at least the following: (1) An explanation of the test, including its purpose, the meaning of its results, and the benefits of early diagnosis and medical intervention; (2) acknowledgment that consent to an HIV test is not a precondition to receiving health care but that refusal to consent may, in some circumstances, affect the provider's ability to diagnose and treat the illness; (3) an explanation of the procedures to be followed, including that the test is voluntary, and a statement advising the subject on the availability of anonymous testing; and (4) an explanation of the confidentiality protections afforded confidential HIV-related information including the circumstances under which and classes of persons to whom disclosure of such information may be required, authorized or permitted by law.

Such explanation shall specifically acknowledge that known partners of the protected individual may be warned of their potential risk of infection without identifying the protected individual and that the law permits the recording of HIV and AIDS-related information in medical charts and records. Informed consent shall be obtained without undue inducement or any element of compulsion, fraud, deceit, duress or other form of constraint or coercion.

(c) Prior to obtaining informed consent, a person ordering the performance of an HIV-related test shall provide the subject of an HIV-related test, or to a person authorized to consent to health care for the subject, an explanation of the nature of AIDS and HIV-related illness and information about behaviors known to pose risks for transmission of HIV infection.

(d) At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV-related test shall provide the subject of the test or the person authorized to consent to health care for the subject with counseling or referrals for counseling: (1) For coping with the emotional consequences of learning the result; (2) regarding the discrimination problems that disclosure of the result could cause; (3) for behavior change to prevent transmission or contraction of HIV infection; (4) to inform such person of available medical treatments; (5) to work towards the goal of involving a minor's parents or legal guardian in the decision to seek and in the ongoing provision of medical treatment; (6) regarding the need of the test subject to notify his partners and, as appropriate, provide assistance or referrals for assistance in notifying partners; except that if the subject of the test is a minor who was tested without the consent of his parents or guardian, such counseling shall be provided to such minor at the time of communicating such test result to such minor. A health care provider or health facility shall not withhold test results from the protected individual. The protected individual may refuse to receive his test result but the person ordering the performance of the test shall encourage him to receive the result and to adopt behavior changes that will allow him to protect himself and others from infection.

(e) The provisions of this section shall not apply to the performance of an HIV-related test:

(1) By licensed medical personnel when the subject is unable to grant or withhold consent and no other person is available who is authorized to consent to health care for the individual and the test results are needed for diagnostic purposes to provide appropriate urgent care, except that in such cases the counseling, referrals and notification of test results described in subsection (d) of this section shall be provided as soon as practical;

(2) By a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals, provided if the test results are communicated to the subject, the counseling, referrals and notification of test results described in subsection (d) of this section shall be provided;

(3) For the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and is unable to be retrieved by the researcher;

(4) On a deceased person when such test is conducted to determine the cause or circumstances of death or for epidemiological purposes;

(5) In cases where a health care provider or other person, including volunteer emergency medical services, fire and public safety personnel, in the course of his occupational duties has had a significant exposure, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his occupation, (B) the worker completes an incident report within forty-eight hours of exposure identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline HIV test within seventy-two hours of the exposure and is negative on that test, (D) the patient's or person's physician or, if the patient or person does not have a personal physician or if the patient's or person's physician is unavailable, another physician or health care provider has approached the patient or person and sought voluntary consent and the patient or person has refused to consent to testing, except in an exposure where the patient or person is deceased, (E) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that the worker has a significant exposure to the blood of a patient or person and the patient or person, or the patient's or person's legal guardian, refuses to grant informed consent for an HIV test. If the patient or person is under the care or custody of the health facility, correctional facility or other institution and a sample of the patient's blood is available, said blood shall be tested. If no sample of blood is available, and the patient is under the care or custody of a health facility, correctional facility or other institution, the patient shall have a blood sample drawn at the health facility, correctional facility or other institution and tested. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorized the HIV testing of a patient or other person, nor the health facility, correctional facility or other institution, nor any person in a health facility or other institution who relies in good faith on the group's

determination and performs that test shall have any liability as a result of his action carried out pursuant to this section, unless such person acted in bad faith. If the patient or person is not under the care or custody of a health facility, correctional facility or other institution and a physician not directly involved in the exposure certifies in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that a significant exposure has occurred, the worker may seek a court order for testing pursuant to subdivision (8) of this subsection, (F) the worker would be able to take meaningful immediate action, if results are known, which could not otherwise be taken, as defined in regulations adopted pursuant to section 19a-589, (G) the fact that an HIV test was given as a result of an accidental exposure and the results of that test shall not appear in a patient's or person's medical record unless such test result is relevant to the medical care the person is receiving at that time in a health facility or correctional facility or other institution, (H) the counseling described in subsection (d) of this section shall be provided but the patient or person may choose not to be informed about the result of the test, and (I) the cost of the HIV test shall be borne by the employer of the potentially exposed worker;
(6) In facilities operated by the Department of Correction if the facility physician determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, provided no reasonable alternative exists that will achieve the same goal;

(7) In facilities operated by the Department of Correction if the facility physician and chief administrator of the facility determine that the behavior of the inmate poses a significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility and no reasonable alternative exists that will achieve the same goal. No involuntary testing shall take place pursuant to subdivisions (6) and (7) of this subsection until reasonable effort has been made to secure informed consent. When testing without consent takes place pursuant to subdivisions (6) and (7) of this subsection, the counseling referrals and notification of test results described in subsection (d) of this section shall, nonetheless be provided;

(8) Under a court order which is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the HIV-related test result which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for a test result against the privacy interests of the test subject and the public interest which may be disserved by involuntary testing, (B) pleadings pertaining to the request for an involuntary test shall substitute a pseudonym for the true name of the subject to be tested. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court, (C) before granting any such order, the court shall provide the individual on whom a test result is being sought with notice and a reasonable opportunity to participate in the proceeding if he is not already a party, (D) court proceedings as to involuntary testing shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice;

(9) When the test is conducted by any life or health insurer or health care center for purposes of assessing a person's fitness for insurance coverage offered by such insurer or health care center; or

(10) When the test is subsequent to a prior confirmed test and the subsequent test is part of a series of repeated testing for the purposes of medical monitoring and treatment, provided (A) the patient has previously given informed consent and has been counseled concerning medical treatments and behavioral changes necessary to reduce HIV transmission, as required by this section, (B) the patient, after consultation with the health care provider, has declined reiteration of the specific informed consent, counseling and education requirements of this section, and (C) a notation to that effect has been entered into the patient's medical record.

(f) Except as provided in subsection (e) of this section, informed consent as described in this section shall be obtained for each HIV test, or in the case where a sequence of tests is required to confirm an initial positive result, for each sequence of tests.

Connecticut General Statutes

Conn. Gen. Stat. § 19a-584 (2007)
Informing and warning of known partners of possible exposure to the HIV virus.
Disclosure of HIV-related information to public health officers.

(a) A public health officer may inform or warn partners of an individual that they may have been exposed to HIV under the following conditions: (1) The public health officer reasonably believes there is a significant risk of transmission to the partner; (2) the public health officer has counseled the protected individual regarding the need to notify the partner and the public health officer reasonably believes the protected individual will not inform the partner; (3) the public health officer has informed the protected individual of such officer's intent to make such disclosure. The public health officer may also warn or inform a partner at the request of a protected individual. When making such disclosure to the partner the public health officer shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of learning the information and for changing behavior to prevent transmission or contraction of HIV infection. The public health officer shall not disclose the identity of the protected individual or the identity of any other partner. The public health officer, making a notification, shall make such disclosure in person, except where circumstances reasonably prevent doing so. The public health officer shall make a good faith effort to notify the partner of the risk of HIV infection. The public health officer shall have no obligation to warn or inform, identify or locate any partner.

(b) A physician may warn or inform a known partner of a protected individual if both the partner and the protected individual are under the physician's care or the physician may disclose confidential HIV-related information to a public health officer for the purpose of informing or warning partners of the protected individual that they may have been exposed to HIV , under the following conditions: (1) The physician reasonably believes there is a significant risk of transmission to the partner; (2) the physician has counseled the protected individual regarding the need to notify the partner and the physician reasonably believes the protected individual will not inform the partner; (3) the physician has informed the protected individual of such physician's intent to make such disclosure to the partner or public health officer. The physician may also warn or inform a partner at the request of a protected individual. When making such disclosure to the partner the physician shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of learning the information and for changing behavior to prevent transmission or contraction of HIV infection. The physician or public health officer shall not disclose the identity of the protected individual or the identity of any other partner. The public health officer or physician making a notification shall make such disclosure in person, except where circumstances reasonably prevent doing so. Upon receiving such a request for assistance, the public health officer shall make a good faith effort to notify said partner of the risk of HIV infection. The physician or public health officer shall have no obligation to warn or inform, identify or locate any partner. The physician shall have no obligation to disclose information to a public health officer for the purpose of warning or informing a partner.

(c) For purposes of this section, "public health officer" means an employee of the Department of Public Health designated by the commissioner or if authorized by the commissioner, a local health director, or such director's designee.

Conn. Gen. Stat. § 19a-592 (2007)
Testing and treatment of minor for HIV or AIDS.
Confidentiality.
Liability for costs.

(a) Any licensed physician may examine and provide treatment for human immunodeficiency virus infection, or acquired immune deficiency syndrome for a minor, only with the consent of the parents or guardian of the minor unless the physician determines that notification of the parents or guardian of the minor will result in treatment being denied or the physician determines the minor will not seek, pursue or continue treatment if the parents or guardian are notified and the minor requests that his parents or guardian not be notified. The physician shall fully document the reasons for the determination to provide treatment without the consent or notification of the parents or guardian of the minor and shall include such documentation, signed by the minor, in the minor's clinical record. The fact of consultation, examination and treatment of a minor under the provisions of this section shall be confidential and shall not be divulged without the minor's consent, including the sending of a bill for the services to any person other than the minor until the physician consults with the minor regarding the sending of a bill.

(b) A minor shall be personally liable for all costs and expenses for services afforded him at his request under this section.

Connecticut General Statutes

Conn. Gen. Stat. § 19a-600 (2007)
Definitions.

For the purposes of sections 19a-601 and 19a-602:
(1) "**Counselor**" means: (A) A psychiatrist, (B) a psychologist licensed under chapter 383, [FN1] (C) clinical social worker licensed under chapter 383b, [FN2] (D) a marital and family therapist licensed under chapter 383a, [FN3] (E) an ordained member of the clergy, (F) a physician assistant licensed under section 20-12b, (G) a nurse-midwife licensed under chapter 377, [FN4] (H) a certified guidance counselor, (I) a registered professional nurse licensed under chapter 378, [FN5] or (J) a practical nurse licensed under chapter 378.

(2) "**Minor**" means a person who is less than sixteen years of age.

[FN1] C.G.S.A. § 20-186 et seq.
[FN2] C.G.S.A. § 20-195m et seq.
[FN3] C.G.S.A. § 20-195a et seq.
[FN4] C.G.S.A. § 20-86a et seq.
[FN5] C.G.S.A. § 20-87 et seq.

Conn. Gen. Stat. § 19a-601 (2007)
Information and counseling for minors required. Medical emergency exception.

(a) Prior to the performance of an abortion upon a minor, a physician or counselor shall provide pregnancy information and counseling in accordance with this section in a manner and language that will be understood by the minor. The physician or counselor shall:

(1) Explain that the information being given to the minor is being given objectively and is not intended to coerce, persuade or induce the minor to choose to have an abortion or to carry the pregnancy to term;

(2) Explain that the minor may withdraw a decision to have an abortion at any time before the abortion is performed or may reconsider a decision not to have an abortion at any time within the time period during which an abortion may legally be performed;

(3) Explain to the minor the alternative choices available for managing the pregnancy, including: (A) Carrying the pregnancy to term and keeping the child, (B) carrying the pregnancy to term and placing the child for adoption, placing the child with a relative or obtaining voluntary foster care for the child, and (C) having an abortion, and explain that public and private agencies are available to assist the minor with whichever alternative she chooses and that a list of these agencies and the services available from each will be provided if the minor requests;

(4) Explain that public and private agencies are available to provide birth control information and that a list of these agencies and the services available from each will be provided if the minor requests;

(5) Discuss the possibility of involving the minor's parents, guardian or other adult family members in the minor's decision-making concerning the pregnancy and whether the minor believes that involvement would be in the minor's best interests; and

(6) Provide adequate opportunity for the minor to ask any questions concerning the pregnancy, abortion, child care and adoption, and provide information the minor seeks or, if the person cannot provide the information, indicate where the minor can receive the information.

(b) After the person provides the information and counseling to a minor as required by this section, such person shall have the minor sign and date a form stating that:

(1) The minor has received information on alternatives to abortion and that there are agencies that will provide assistance and that a list of these agencies and the services available from each will be provided if the minor requests;

(2) The minor has received an explanation that the minor may withdraw an abortion decision or reconsider a decision to carry a pregnancy to term;

(3) The alternatives available for managing the pregnancy have been explained to the minor;

(4) The minor has received an explanation about agencies available to provide birth control information and that a list of these agencies and the services available from each will be provided if the minor requests;

(5) The minor has discussed with the person providing the information and counseling the possibility of involving the minor's parents, guardian or other adult family members in the minor's decision-making about the pregnancy;

(6) If applicable, the minor has determined that not involving the minor's parents, guardian or other adult family members is in the minor's best interests; and

(7) The minor has been given an adequate opportunity to ask questions.

(c) The person providing the information and counseling shall also sign and date the form and shall include such person's business address and business telephone number. The person shall keep a copy for such minor's medical record and shall give the form to the minor or, if the minor requests and if such person is not the attending physician, transmit the form to the minor's attending physician. Such medical record shall be maintained as otherwise provided by law.

(d) The provision of pregnancy information and counseling by a physician or counselor which is evidenced in writing containing the information and statements provided in this section and which is signed by the minor shall be presumed to be evidence of compliance with the requirements of this section.

(e) The requirements of this section shall not apply when, in the best medical judgment of the physician based on the facts of the case before him, a medical emergency exists that so complicates the pregnancy or the health, safety or well-being of the minor as to require an immediate abortion. A physician who does not comply with the requirements of this section by reason of this exception shall state in the medical record of the abortion the medical indications on which his judgment was based.

Conn. Gen. Stat. § 19a-602 (2007)

Termination of pregnancy prior to viability.
Abortion after viability prohibited; exception.

(a) The decision to terminate a pregnancy prior to the viability of the fetus shall be solely that of the pregnant woman in consultation with her physician.

(b) No abortion may be performed upon a pregnant woman after viability of the fetus except when necessary to preserve the life or health of the pregnant woman.

Conn. Gen. Stat. § 20-7b (2007)

Definitions.

For purposes of sections 20-7b to 20-7e, inclusive:

(a) "**Patient**" means a natural person who has received health care services from a provider for treatment of a medical condition, or a person he designates in writing as his representative; and

(b) "**Provider**" means any person or organization that furnishes health care services and is licensed or certified to furnish such services pursuant to chapters 370 to 373, inclusive, 375 to 384a, inclusive, 388, 398 and 399 or is licensed or certified pursuant to chapter 368d.

Conn. Gen. Stat. § 20-7c (2007)

Access to medical records.
Mandatory notification to patient of certain test results.

(a) For purposes of this section, "provider" has the same meaning as provided in section 20-7b.

(b) (1) A provider, except as provided in section 4-194, shall supply to a patient upon request complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient. (2) A provider shall notify a patient of any test results in the provider's possession or requested by the provider for the purposes of diagnosis, treatment or prognosis of such patient.

(c) Upon a written request of a patient, a patient' s attorney or authorized representative, or pursuant to a written authorization, a provider, except as provided in section 4-194, shall furnish to the person making such request a copy of the patient's health record, including but not limited to, bills, x-rays and copies of laboratory reports, contact lens specifications based on examinations and final contact lens fittings given within the preceding three months or such longer period of time as determined by the provider but no longer than six months, records of prescriptions and other technical information used in assessing the patient's health condition. No provider shall charge more than forty-five cents per page, including any research fees, handling fees or related costs, and the cost of first class postage, if applicable, for furnishing a health record pursuant to this subsection, except such provider may charge a patient the amount necessary to cover the cost of materials for furnishing a copy of an x-ray, provided no such charge shall be made for furnishing a health record or part thereof to a patient, a patient's attorney or authorized representative if the record or part thereof is necessary for the purpose of supporting a claim or appeal under any provision of the Social Security Act [FN1] and the request is accompanied by documentation of the claim or appeal. A provider shall furnish a health record requested pursuant to this section within thirty days of the request.

(d) If a provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to harm himself or another, the provider may withhold the information from the patient. The information may be supplied to an appropriate third party or to another provider who may release the information

to the patient. If disclosure of information is refused by a provider under this subsection, any person aggrieved thereby may, within thirty days of such refusal, petition the superior court for the judicial district in which such person resides for an order requiring the provider to disclose the information. Such a proceeding shall be privileged with respect to assignment for trial. The court, after hearing and an in camera review of the information in question, shall issue the order requested unless it determines that such disclosure would be detrimental to the physical or mental health of the person or is likely to cause the person to harm himself or another.

(e) The provisions of this section shall not apply to any information relative to any psychiatric or psychological problems or conditions.

[FN1] 42 U.S.C.A. § 301 et seq.

Conn. Gen. Stat. § 20-7d (2007)

Release of patient's medical records to another provider.

A copy of the patient's health record, including but not limited to, x-rays and copies of laboratory reports, prescriptions and other technical information used in assessing the patient's condition shall be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Conn. Gen. Stat. § 45a-604 (2007) (Formerly Sec. 45-42a)

Definitions.

As used in sections 45a-603 to 45a-622, inclusive:

(1) "**Mother**" means a woman who can show proof by means of a birth certificate or other sufficient evidence of having given birth to a child and an adoptive mother as shown by a decree of a court of competent jurisdiction or otherwise;

(2) "**Father**" means a man who is a father under the law of this state including a man who, in accordance with section 46b-172, executes a binding acknowledgment of paternity and a man determined to be a father under chapter 815y;

(3) "**Parent**" means a mother as defined in subdivision (1) of this section or a "father" as defined in subdivision (2) of this section;

(4) "**Minor**" or "**minor child**" means a person under the age of eighteen;

(5) "**Guardianship**" means guardianship of the person of a minor, and includes: (A) The obligation of care and control; (B) the authority to make major decisions affecting the minor's education and welfare, including, but not limited to, consent determinations regarding marriage, enlistment in the armed forces and major medical, psychiatric or surgical treatment; and (C) upon the death of the minor, the authority to make decisions concerning funeral arrangements and the disposition of the body of the minor;

(6) "**Guardian**" means one who has the authority and obligations of "guardianship" as defined in subdivision (5) of this section;

(7) "**Termination of parental rights**" means the complete severance by court order of the legal relationship, with all its rights and responsibilities, between the child and the child's parent or parents so that the child is free for adoption, except that it shall not affect the right of inheritance of the child or the religious affiliation of the child.

Conn. Gen. Stat. § 46b-56 (2007)

Orders re custody, care, education, visitation and support of children.
Best interests of the child.
Access to records of minor children by noncustodial parent.
Orders re therapy, counseling and drug or alcohol screening.

(a) In any controversy before the Superior Court as to the custody or care of minor children, and at any time after the return day of any complaint under section 46b-45, the court may make or modify any proper order regarding the custody, care, education, visitation and support of the children if it has jurisdiction under the provisions of chapter 815p. [FN1] Subject to the provisions of section 46b-56a, the court may assign parental responsibility for raising the child to the parents jointly, or may award custody to either parent or to a third party, according to its best judgment upon the facts of the case and subject to such conditions and limitations as it deems equitable. The court may also make any order granting the right of visitation of any child to a third party to the action, including, but not limited to, grandparents.

(b) In making or modifying any order as provided in subsection (a) of this section, the rights and responsibilities of both parents shall be considered and the court shall enter orders accordingly that serve the best interests of the child and provide the child with the active and consistent

involvement of both parents commensurate with their abilities and interests. Such orders may include, but shall not be limited to: (1) Approval of a parental responsibility plan agreed to by the parents pursuant to section 46b-56a; (2) the award of joint parental responsibility of a minor child to both parents, which shall include (A) provisions for residential arrangements with each parent in accordance with the needs of the child and the parents, and (B) provisions for consultation between the parents and for the making of major decisions regarding the child's health, education and religious upbringing; (3) the award of sole custody to one parent with appropriate parenting time for the noncustodial parent where sole custody is in the best interests of the child; or (4) any other custody arrangements as the court may determine to be in the best interests of the child.

(c) In making or modifying any order as provided in subsections (a) and (b) of this section, the court shall consider the best interests of the child, and in doing so may consider, but shall not be limited to, one or more of the following factors: (1) The temperament and developmental needs of the child; (2) the capacity and the disposition of the parents to understand and meet the needs of the child; (3) any relevant and material information obtained from the child, including the informed preferences of the child; (4) the wishes of the child's parents as to custody; (5) the past and current interaction and relationship of the child with each parent, the child's siblings and any other person who may significantly affect the best interests of the child; (6) the willingness and ability of each parent to facilitate and encourage such continuing parent-child relationship between the child and the other parent as is appropriate, including compliance with any court orders; (7) any manipulation by or coercive behavior of the parents in an effort to involve the child in the parents' dispute; (8) the ability of each parent to be actively involved in the life of the child; (9) the child's adjustment to his or her home, school and community environments; (10) the length of time that the child has lived in a stable and satisfactory environment and the desirability of maintaining continuity in such environment, provided the court may consider favorably a parent who voluntarily leaves the child's family home pendente lite in order to alleviate stress in the household; (11) the stability of the child's existing or proposed residences, or both; (12) the mental and physical health of all individuals involved, except that a disability of a proposed custodial parent or other party, in and of itself, shall not be determinative of custody unless the proposed custodial arrangement is not in the best interests of the child; (13) the child's cultural background; (14) the effect on the child of the actions of an abuser, if any domestic violence has occurred between the parents or between a parent and another individual or the child; (15) whether the child or a sibling of the child has been abused or neglected, as defined respectively in section 46b-120; and (16) whether the party satisfactorily completed participation in a parenting education program established pursuant to section 46b-69b. The court is not required to assign any weight to any of the factors that it considers.

(d) Upon the issuance of any order assigning custody of the child to the Commissioner of Children and Families, or not later than sixty days after the issuance of such order, the court shall make a determination whether the Department of Children and Families made reasonable efforts to keep the child with his or her parents prior to the issuance of such order and, if such efforts were not made, whether such reasonable efforts were not possible, taking into consideration the best interests of the child, including the child's health and safety.

(e) In determining whether a child is in need of support and, if in need, the respective abilities of the parents to provide support, the court shall take into consideration all the factors enumerated in section 46b-84.

(f) When the court is not sitting, any judge of the court may make any order in the cause which the court might make under this section, including orders of injunction, prior to any action in the cause by the court.

(g) A parent not granted custody of a minor child shall not be denied the right of access to the academic, medical, hospital or other health records of such minor child, unless otherwise ordered by the court for good cause shown.

(h) Notwithstanding the provisions of subsections (b) and (c) of this section, when a motion for modification of custody or visitation is pending before the court or has been decided by the court and the investigation ordered by the court pursuant to section 46b-6 recommends psychiatric or psychological therapy for a child, and such therapy would, in the court's opinion, be in the best interests of the child and aid the child's response to a modification, the court may order such therapy and reserve judgment on the motion for modification.

(i) As part of a decision concerning custody or visitation, the court may order either parent or both of the parents and any child of such parents to participate in counseling and drug or alcohol screening, provided such participation is in the best interests of the child.

[FN1] C.G.S.A. § 46b-115 et seq.

Connecticut General Statutes

Conn. Gen. Stat. § 46b-120 (2007) (Effective Oct. 1, 2007)
Definitions.

The terms used in this chapter shall, in its interpretation and in the interpretation of other statutes, be defined as follows:

(1) "**Child**" means any person under sixteen years of age and, for purposes of delinquency matters, "child" means any person (A) under sixteen years of age, or (B) sixteen years of age or older who, prior to attaining sixteen years of age, has violated any federal or state law or municipal or local ordinance, other than an ordinance regulating behavior of a child in a family with service needs, and, subsequent to attaining sixteen years of age, violates any order of the Superior Court or any condition of probation ordered by the Superior Court with respect to such delinquency proceeding;

(2) "**Youth**" means any person sixteen or seventeen years of age;

(3) "**Youth in Crisis**" means any youth who, within the last two years, (A) has without just cause run away from the parental home or other properly authorized and lawful place of abode, (B) is beyond the control of the youth's parents, guardian or other custodian, or (C) has four unexcused absences from school in any one month or ten unexcused absences in any school year;

(4) "**Abused**" means that a child or youth (A) has been inflicted with physical injury or injuries other than by accidental means, or (B) has injuries that are at variance with the history given of them, or (C) is in a condition that is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment;

(5) A child may be found "**mentally deficient**" who, by reason of a deficiency of intelligence that has existed from birth or from early age, requires, or will require, for his protection or for the protection of others, special care, supervision and control;

(6) A child may be convicted as "**delinquent**" who has violated (A) any federal or state law or municipal or local ordinance, other than an ordinance regulating behavior of a child in a family with service needs, (B) any order of the Superior Court, except as provided in section 46b-148, or (C) conditions of probation as ordered by the court;

(7) A child or youth may be found "**dependent**" whose home is a suitable one for the child or youth, save for the financial inability of the child's or youth's parents, parent or guardian, or other person maintaining such home, to provide the specialized care the condition of the child or youth requires;

(8) "**Family with Service Needs**" means a family that includes a child who (A) has without just cause run away from the parental home or other properly authorized and lawful place of abode, (B) is beyond the control of the child's parent, parents, guardian or other custodian, (C) has engaged in indecent or immoral conduct, (D) is a truant or habitual truant or who, while in school, has been continuously and overtly defiant of school rules and regulations, or (E) is thirteen years of age or older and has engaged in sexual intercourse with another person and such other person is thirteen years of age or older and not more than two years older or younger than such child;

(9) A child or youth may be found "**neglected**" who (A) has been abandoned, or (B) is being denied proper care and attention, physically, educationally, emotionally or morally, or (C) is being permitted to live under conditions, circumstances or associations injurious to the well-being of the child or youth, or (D) has been abused;

(10) A child or youth may be found "**uncared for**" who is homeless or whose home cannot provide the specialized care that the physical, emotional or mental condition of the child requires. For the purposes of this section, the treatment of any child by an accredited Christian Science practitioner, in lieu of treatment by a licensed practitioner of the healing arts, shall not of itself constitute neglect or maltreatment;

(11) "**Delinquent act**" means the violation of any federal or state law or municipal or local ordinance, other than an ordinance regulating the behavior of a child in a family with service needs, or the violation of any order of the Superior Court;

(12) "**Serious juvenile offense**" means (A) the violation of, including attempt or conspiracy to violate, section 21a-277, 21a-278, 29-33, 29-34, 29-35, 53-21, 53-80a, 53-202b, 53-202c, 53-390 to 53-392, inclusive, 53a-54a to 53a-57, inclusive, 53a-59 to 53a-60c, inclusive, 53a-70 to 53a-71, inclusive, 53a-72b, 53a-86, 53a-92 to 53a-94a, inclusive, 53a-95, 53a-101, 53a-102a, 53a-103a or 53a-111 to 53a-113, inclusive, subdivision (1) of subsection (a) of section 53a-122, subdivision (3) of subsection (a) of section 53a-123, section 53a-134, 53a-135, 53a-136a, 53a-166 or 53a-167c, subsection (a) of section 53a-174, or section 53a-196a, 53a-211, 53a-212, 53a-216 or 53a-217b, by a child, or (B) running away, without just cause, from any secure placement other than home while referred as a delinquent child to the Court Support Services Division or committed as a delinquent child to the Commissioner of Children and Families for a serious juvenile offense;

(13) "**Serious juvenile offender**" means any child convicted as delinquent for commission of a serious juvenile offense;

(14) "**Serious juvenile repeat offender**" means any child charged with the commission of any felony if such child has previously been convicted delinquent at any age for two violations of any provision of title 21a, 29, 53 or 53a that is designated as a felony;

(15) "**Alcohol-dependent child**" means any child who has a psychoactive substance dependence on alcohol as that condition is defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"; and

(**16)** "**Drug-dependent child**" means any child who has a psychoactive substance dependence on drugs as that condition is defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". No child shall be classified as drug dependent who is dependent (A) upon a morphine-type substance as an incident to current medical treatment of a demonstrable physical disorder other than drug dependence, or (B) upon amphetamine-type, ataractic, barbiturate-type, hallucinogenic or other stimulant and depressant substances as an incident to current medical treatment of a demonstrable physical or psychological disorder, or both, other than drug dependence.

Conn. Gen. Stat. §46b-150 (2007) (Effective Oct. 1, 2007)

Emancipation of minor.
Procedure.
Notice.
Attorney General as party.

Any minor who has reached such minor's sixteenth birthday and is residing in this state, or any parent or guardian of such minor, may petition the superior court for juvenile matters or the probate court for the district in which either the minor or the parents or guardian of such minor resides for a determination that the minor named in the petition be emancipated. The petition shall be verified and shall state plainly: (1) The facts which bring the minor within the jurisdiction of the court, (2) the name, date of birth, sex and residence of the minor, (3) the name and residence of the minor's parent, parents or guardian, and (4) the name of the petitioner and the petitioner's relationship to the minor. Upon the filing of the petition in the Superior Court, the court shall cause a summons to be issued to the minor and the minor's parent, parents or guardian, in the manner provided in section 46b-128. Service on an emancipation petition filed in the superior court for juvenile matters pursuant to this section shall not be required on the petitioning party. Upon the filing of the petition in the Probate Court, the court shall assign a time, not later than thirty days thereafter, and a place for hearing such petition. The court shall cause a citation and notice to be served on the minor and the minor's parent, if the parent is not the petitioner, by personal service or service at the minor's place of abode and the parent's place of abode, at least seven days prior to the hearing date, by a state marshal, constable or indifferent person. The court shall direct notice by first class mail to the parent, if the parent is the petitioner. The court shall order such notice as it directs to: (A) The Commissioner of Children and Families, (B) the Attorney General, and (C) other persons having an interest in the minor. The Attorney General may file an appearance and shall be and remain a party to the action if the child is receiving or has received aid or care from the state, or if the child is receiving child support enforcement services, as defined in subdivision (2) of subsection (b) of section 46b-231.

Conn. Gen. Stat. § 46b-150b

Order of emancipation.

If the Superior Court or the Probate Court, after hearing, finds that: (1) The minor has entered into a valid marriage, whether or not that marriage has been terminated by dissolution; or (2) the minor is on active duty with any of the armed forces of the United States of America; or (3) the minor willingly lives separate and apart from his parents or guardian, with or without the consent of the parents or guardian, and that the minor is managing his own financial affairs, regardless of the source of any lawful income; or (4) for good cause shown, it is in the best interest of the minor, any child of the minor or the parents or guardian of the minor, the court may enter an order declaring that the minor is emancipated.

Conn. Gen. Stat. § 46b-150d

Effect of emancipation.

An order that a minor is emancipated shall have the following effects: (1) The minor may consent to medical, dental or psychiatric care, without parental consent, knowledge or liability; (2) the minor may enter into a binding contract; (3) the minor may sue and be sued in such minor's own name; (4) the minor shall be entitled to such minor's own earnings and shall be free of control by such minor's parents or guardian; (5) the minor may establish such minor's own residence; (6) the minor may buy and sell real and personal property; (7) the minor may not thereafter be the subject of a petition under section 46b-129 as an abused, dependent, neglected or uncared for child or youth;

(8) the minor may enroll in any school or college, without parental consent; (9) the minor shall be deemed to be over eighteen years of age for purposes of securing an operator's license under section 14-36 and a marriage license under subsection (b) of section 46b-30 or a civil union license under section 46b-38jj without parental consent; (10) the minor shall be deemed to be over eighteen years of age for purposes of registering a motor vehicle under section 14-12; (11) the parents of the minor shall no longer be the guardians of the minor under section 45a-606; (12) the parents of a minor shall be relieved of any obligations respecting such minor's school attendance under section 10-184; (13) the parents shall be relieved of all obligation to support the minor; (14) the minor shall be emancipated for the purposes of parental liability for such minor's acts under section 52-572; (15) the minor may execute releases in such minor's own name under section 14-118; and (16) the minor may enlist in the armed forces of the United States without parental consent.

Conn. Gen. Stat. § 52-146c

Privileged communications between psychologist and patient.

(a) As used in this section:
(1) "Person" means an individual who consults a psychologist for purposes of diagnosis or treatment;

(2) "Psychologist" means an individual licensed to practice psychology pursuant to chapter 383;

(3) "Communications" means all oral and written communications and records thereof relating to the diagnosis and treatment of a person between such person and a psychologist or between a member of such person's family and a psychologist;

(4) "Consent" means consent given in writing by the person or his authorized representative;

(5) "Authorized representative" means (A) an individual empowered by a person to assert the confidentiality of communications which are privileged under this section, or (B) if a person is deceased, his personal representative or next of kin, or (C) if a person is incompetent to assert or waive his privileges hereunder, (i) a guardian or conservator who has been or is appointed to act for the person, or (ii) for the purpose of maintaining confidentiality until a guardian or conservator is appointed, the person's nearest relative.

(b) Except as provided in subsection (c) of this section, in civil and criminal actions, in juvenile, probate, commitment and arbitration proceedings, in proceedings preliminary to such actions or proceedings, and in legislative and administrative proceedings, all communications shall be privileged and a psychologist shall not disclose any such communications unless the person or his authorized representative consents to waive the privilege and allow such disclosure. The person or his authorized representative may withdraw any consent given under the provisions of this section at any time in a writing addressed to the individual with whom or the office in which the original consent was filed. The withdrawal of consent shall not affect communications disclosed prior to notice of the withdrawal.

(c) Consent of the person shall not be required for the disclosure of such person's communications:

(1) If a judge finds that any person after having been informed that the communications would not be privileged, has made the communications to a psychologist in the course of a psychological examination ordered by the court, provided the communications shall be admissible only on issues involving the person's psychological condition;

(2) If, in a civil proceeding, a person introduces his psychological condition as an element of his claim or defense or, after a person's death, his condition is introduced by a party claiming or defending through or as a beneficiary of the person, and the judge finds that it is more important to the interests of justice that the communications be disclosed than that the relationship between the person and psychologist be protected;

(3) If the psychologist believes in good faith that there is risk of imminent personal injury to the person or to other individuals or risk of imminent injury to the property of other individuals;

(4) If child abuse, abuse of an elderly individual or abuse of an individual who is disabled or incompetent is known or in good faith suspected;

(5) If a psychologist makes a claim for collection of fees for services rendered, the name and address of the person and the amount of the fees may be disclosed to individuals or agencies involved in such collection, provided notification that such disclosure will be made is sent, in writing, to the person not less than thirty days prior to such disclosure. In cases where a dispute arises over the fees or claims or where additional information is needed to substantiate the claim, the disclosure of further information shall be limited to the following: (A) That the person was in fact receiving psychological services, (B) the dates of such services, and (C) a general description of the types of services; or

(6) If the communications are disclosed to a member of the immediate family or legal representative of the victim of a

homicide committed by the person where such person has, on or after July 1, 1989, been found not guilty of such offense by reason of mental disease or defect pursuant to section 53a-13, provided such family member or legal representative requests the disclosure of such communications not later than six years after such finding, and provided further, such communications shall only be available during the pendency of, and for use in, a civil action relating to such person found not guilty pursuant to section 53a-13.

Conn. Gen. Stat. § 52-146d (Formerly Sec. 52-146a)

Privileged communications between psychiatrist and patient.
Definitions.

As used in sections 52-146d to 52-146i, inclusive:

(1) "**Authorized representative**" means (A) a person empowered by a patient to assert the confidentiality of communications or records which are privileged under sections 52-146c to 52-146i, inclusive, or (B) if a patient is deceased, his personal representative or next of kin, or (C) if a patient is incompetent to assert or waive his privileges hereunder, (i) a guardian or conservator who has been or is appointed to act for the patient, or (ii) for the purpose of maintaining confidentiality until a guardian or conservator is appointed, the patient's nearest relative;

(2) "**Communications and records**" means all oral and written communications and records thereof relating to diagnosis or treatment of a patient's mental condition between the patient and a psychiatrist, or between a member of the patient's family and a psychiatrist, or between any of such persons and a person participating under the supervision of a psychiatrist in the accomplishment of the objectives of diagnosis and treatment, wherever made, including communications and records which occur in or are prepared at a mental health facility;

(3) "**Consent**" means consent given in writing by the patient or his authorized representative;

(4) "**Identifiable**" and "identify a patient" refer to communications and records which contain (A) names or other descriptive data from which a person acquainted with the patient might reasonably recognize the patient as the person referred to, or (B) codes or numbers which are in general use outside of the mental health facility which prepared the communications and records;

(5) "**Mental health facility**" includes any hospital, clinic, ward, psychiatrist's office or other facility, public or private, which provides inpatient or outpatient service, in whole or in part, relating to the diagnosis or treatment of a patient's mental condition;

(6) "**Patient**" means a person who communicates with or is treated by a psychiatrist in diagnosis or treatment;

(7) "**Psychiatrist**" means a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed by the patient to be so qualified.

Conn. Gen. Stat. § 52-146j

Judicial relief.

(a) Any person aggrieved by a violation of sections 52-146d to 52-146j, inclusive, may petition the superior court for the judicial district in which he resides, or, in the case of a nonresident of the state, the superior court for the judicial district of Hartford, for appropriate relief, including temporary and permanent injunctions, and the petition shall be privileged with respect to assignment for trial.

(b) Any person aggrieved by a violation of sections 52-146d to 52-146j, inclusive, may prove a cause of action for civil damages.

Conn. Gen. Stat. § 52-146o

Disclosure of patient communication or information by physician, surgeon or health care provider prohibited.

(a) Except as provided in sections 52-146c to 52-146j, inclusive, and subsection (b) of this section, in any civil action or any proceeding preliminary thereto or in any probate, legislative or administrative proceeding, a physician or surgeon, as defined in subsection (b) of section 20-7b, shall not disclose (1) any communication made to him by, or any information obtained by him from, a patient or the conservator or guardian of a patient with respect to any actual or supposed physical or mental disease or disorder or (2) any information obtained by personal examination of a patient, unless the patient or his authorized representative explicitly consents to such disclosure.

(b) Consent of the patient or his authorized representative shall not be required for the disclosure of such communication or information (1) pursuant to any statute or regulation of any state agency or the rules of court, (2) by a physician, surgeon or other licensed health care provider

against whom a claim has been made, or there is a reasonable belief will be made, in such action or proceeding, to his attorney or professional liability insurer or such insurer's agent for use in the defense of such action or proceeding, (3) to the Commissioner of Public Health for records of a patient of a physician, surgeon or health care provider in connection with an investigation of a complaint, if such records are related to the complaint, or (4) if child abuse, abuse of an elderly individual, abuse of an individual who is physically disabled or incompetent or abuse of an individual with mental retardation is known or in good faith suspected.

Conn. Gen. Stat. § 53a-65
Definitions.

As used in this part, except section 53a-70b, the following terms have the following meanings:
(1) "**Actor**" means a person accused of sexual assault.

(2) "**Sexual intercourse**" means vaginal intercourse, anal intercourse, fellatio or cunnilingus between persons regardless of sex. Its meaning is limited to persons not married to each other. Penetration, however slight, is sufficient to complete vaginal intercourse, anal intercourse or fellatio and does not require emission of semen. Penetration may be committed by an object manipulated by the actor into the genital or anal opening of the victim's body.

(3) "**Sexual contact**" means any contact with the intimate parts of a person not married to the actor for the purpose of sexual gratification of the actor or for the purpose of degrading or humiliating such person or any contact of the intimate parts of the actor with a person not married to the actor for the purpose of sexual gratification of the actor or for the purpose of degrading or humiliating such person.

(4) "**Mentally defective**" means that a person suffers from a mental disease or defect which renders such person incapable of appraising the nature of such person's conduct.

(5) "**Mentally incapacitated**" means that a person is rendered temporarily incapable of appraising or controlling such person's conduct owing to the influence of a drug or intoxicating substance administered to such person without such person's consent, or owing to any other act committed upon such person without such person's consent.

(6) "**Physically helpless**" means that a person is unconscious or for any other reason is physically unable to communicate unwillingness to an act.

(7) "**Use of force**" means: (A) Use of a dangerous instrument; or (B) use of actual physical force or violence or superior physical strength against the victim.

(8) "I**ntimate parts**" means the genital area or any substance emitted therefrom, groin, anus or any substance emitted therefrom, inner thighs, buttocks or breasts.

(9) "**Psychotherapist**" means a physician, psychologist, nurse, substance abuse counselor, social worker, clergyman, marital and family therapist, mental health service provider, hypnotist or other person, whether or not licensed or certified by the state, who performs or purports to perform psychotherapy.

(10) "**Psychotherapy**" means the professional treatment, assessment or counseling of a mental or emotional illness, symptom or condition.

(11) "**Emotionally dependent**" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the patient or former patient is unable to withhold consent to sexual contact by or sexual intercourse with the psychotherapist.

(12) "**Therapeutic deception**" means a representation by a psychotherapist that sexual contact by or sexual intercourse with the psychotherapist is consistent with or part of the patient's treatment.

(13) "**School employee**" means a teacher, substitute teacher, school administrator, school superintendent, guidance counselor, psychologist, social worker, nurse, physician, school paraprofessional or coach employed by a local or regional board of education or a private elementary or secondary school or working in a public or private elementary or secondary school.

Conn. Gen. Stat. § 53a-67
Affirmative defenses.

(a) In any prosecution for an offense under this part based on the victim's being mentally defective, mentally incapacitated or physically helpless, it shall be an affirmative defense that the actor, at the time such actor engaged in the conduct constituting the offense, did not know of such condition of the victim.

(b) In any prosecution for an offense under this part, except an offense under section 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a or 53a-72b, it shall be an affirmative defense that

the defendant and the alleged victim were, at the time of the alleged offense, living together by mutual consent in a relationship of cohabitation, regardless of the legal status of their relationship.

Conn. Gen. Stat. § 53a-70
Sexual assault in the first degree: Class B or A felony.

(a) A person is guilty of sexual assault in the first degree when such person (1) compels another person to engage in sexual intercourse by the use of force against such other person or a third person, or by the threat of use of force against such other person or against a third person which reasonably causes such person to fear physical injury to such person or a third person, or (2) engages in sexual intercourse with another person and such other person is under thirteen years of age and the actor is more than two years older than such person, or (3) commits sexual assault in the second degree as provided in section 53a-71 and in the commission of such offense is aided by two or more other persons actually present, or (4) engages in sexual intercourse with another person and such other person is mentally incapacitated to the extent that such other person is unable to consent to such sexual intercourse.

(b) (1) Except as provided in subdivision (2) of this subsection, sexual assault in the first degree is a class B felony for which two years of the sentence imposed may not be suspended or reduced by the court or, if the victim of the offense is under ten years of age, for which ten years of the sentence imposed may not be suspended or reduced by the court.

(2) Sexual assault in the first degree is a class A felony if the offense is a violation of subdivision (1) of subsection (a) of this section and the victim of the offense is under sixteen years of age or the offense is a violation of subdivision (2) of subsection (a) of this section. Any person found guilty under said subdivision (1) or (2) shall be sentenced to a term of imprisonment of which ten years of the sentence imposed may not be suspended or reduced by the court if the victim is under ten years of age or of which five years of the sentence imposed may not be suspended or reduced by the court if the victim is under sixteen years of age.
(3) Any person found guilty under this section shall be sentenced to a term of imprisonment and a period of special parole pursuant to subsection (b) of section 53a-28 which together constitute a sentence of at least ten years.

Conn. Gen. Stat. § 53a-71 (2007) (Effective Oct. 1, 2007)
Sexual assault in the second degree: Class C or B felony.

(a) A person is guilty of sexual assault in the second degree when such person engages in sexual intercourse with another person and: (1) Such other person is thirteen years of age or older but under sixteen years of age and the actor is more than three years older than such other person; or (2) such other person is mentally defective to the extent that such other person is unable to consent to such sexual intercourse; or (3) such other person is physically helpless; or (4) such other person is less than eighteen years old and the actor is such person's guardian or otherwise responsible for the general supervision of such person's welfare; or (5) such other person is in custody of law or detained in a hospital or other institution and the actor has supervisory or disciplinary authority over such other person; or (6) the actor is a psychotherapist and such other person is (A) a patient of the actor and the sexual intercourse occurs during the psychotherapy session, (B) a patient or former patient of the actor and such patient or former patient is emotionally dependent upon the actor, or (C) a patient or former patient of the actor and the sexual intercourse occurs by means of therapeutic deception; or (7) the actor accomplishes the sexual intercourse by means of false representation that the sexual intercourse is for a bona fide medical purpose by a health care professional; or (8) the actor is a school employee and such other person is a student enrolled in a school in which the actor works or a school under the jurisdiction of the local or regional board of education which employs the actor; or (9) the actor is a coach in an athletic activity or a person who provides intensive, ongoing instruction and such other person is a recipient of coaching or instruction from the actor and (A) is a secondary school student and receives such coaching or instruction in a secondary school setting, or (B) is under eighteen years of age; or (10) the actor is twenty years of age or older and stands in a position of power, authority or supervision over such other person by virtue of the actor's professional, legal, occupational or volunteer status and such other person's participation in a program or activity, and such other person is under eighteen years of age.

(b) Sexual assault in the second degree is a class C felony or, if the victim of the offense is under sixteen years of age, a class B felony, and any person found guilty under this section shall be sentenced to a term of imprisonment of which nine months of the sentence imposed may not be suspended or reduced by the court.

Connecticut General Statutes

Conn. Gen. Stat. § 53a-73a (2007) (Effective Oct. 1, 2007)
Sexual assault in the fourth degree: Class A misdemeanor or class D felony.

(a) A person is guilty of sexual assault in the fourth degree when: (1) Such person intentionally subjects another person to sexual contact who is (A) under thirteen years of age and the actor is more than two years older than such other person, or (B) thirteen years of age or older but under fifteen years of age and the actor is more than three years older than such other person, or (C) mentally defective or mentally incapacitated to the extent that such other person is unable to consent to such sexual contact, or (D) physically helpless, or (E) less than eighteen years old and the actor is such other person's guardian or otherwise responsible for the general supervision of such other person's welfare, or (F) in custody of law or detained in a hospital or other institution and the actor has supervisory or disciplinary authority over such other person; or (2) such person subjects another person to sexual contact without such other person's consent; or (3) such person engages in sexual contact with an animal or dead body; or (4) such person is a psychotherapist and subjects another person to sexual contact who is (A) a patient of the actor and the sexual contact occurs during the psychotherapy session, or (B) a patient or former patient of the actor and such patient or former patient is emotionally dependent upon the actor, or (C) a patient or former patient of the actor and the sexual contact occurs by means of therapeutic deception; or (5) such person subjects another person to sexual contact and accomplishes the sexual contact by means of false representation that the sexual contact is for a bona fide medical purpose by a health care professional; or (6) such person is a school employee and subjects another person to sexual contact who is a student enrolled in a school in which the actor works or a school under the jurisdiction of the local or regional board of education which employs the actor; or (7) such person is a coach in an athletic activity or a person who provides intensive, ongoing instruction and subjects another person to sexual contact who is a recipient of coaching or instruction from the actor and (A) is a secondary school student and receives such coaching or instruction in a secondary school setting, or (B) is under eighteen years of age; or (8) such person subjects another person to sexual contact and (A) the actor is twenty years of age or older and stands in a position of power, authority or supervision over such other person by virtue of the actor's professional, legal, occupational or volunteer status and such other person's participation in a program or activity, and (B) such other person is under eighteen years of age.

(b) Sexual assault in the fourth degree is a class A misdemeanor or, if the victim of the offense is under sixteen years of age, a class D felony.

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Publications from Center for Children's Advocacy

Publications

Teen Legal Rights Pamphlet Series and Poster
This series of question & answer pamplets is written and designed for teens and covers important legal rights issues that can help teenagers stay in school. Topics include Homelessness; Emancipation; Financial Aid for College; Truancy; How to Get Child Support; What to Do if you Owe Child Support; Cash Assistance for Teen Parents; Teen Dating Violence; Rights of Teens in DCF Care; Immigration; Juvenile Justice (school re-entry); Bullying; Statutory Rape. The series includes a poster entitled, "Is Love Supposed to Hurt Me?" which offers contact information for teen dating violence/domestic violence help. (2006, 2008)

Is It Confidential? Reproductive Health Care Pamphlet
Published in partnership with Breaking the Cycle, *Is It Confidential?* details teens' rights to confidential reproductive health care. The pamphlet is written for adolescents and covers topics such as confidential testing and treatment of sexually transmitted diseases and HIV/AIDS; confidentiality rights in regard to birth control and abortion; safe havens; schoolbased health services. The pamphlet includes important contact information in Hartford, New Haven and Bridgeport, for clinics, hospitals and community health centers where teens can go for help.(2006)

Truancy: A Closer Look
The Link between Unmet Educational Needs and Truancy
This important report looks closely at the causes of truancy, focusing on the learning characteristics and experiences that may lead to chronic absenteeism. The Center's Truancy Court Prevention Project (TCPP) works to understand these patterns through analysis of students' academic histories. Report includes proactive strategies to prevent truancy. (2006)

Laminated Resource Cards

Medical-Legal Information for Pediatric Providers
Information and contacts on advocacy for common problems confronted by pediatric providers, including screening questions, tips for immigrant families, poverty level guidelines, and over 100 contacts for statewide support services.(2006)

Disability Advocacy: Contacts and Information
An advocacy tool for pediatric and family medicine providers that offers resources, contact information, and advocacy strategies to augment delivery of healthcare services for children with disabilities. (2008)

Educational Advocacy: Legal Rights of Students
Quick Tips on the Educational Rights of Students in Connecticut, including Access to Records, Admission and Re-Admission, Discipline for All Students, Discipline and Special Education, Homelessness (McKinney-Vento), Attendance and Truancy, and Special Education.(2006)

Video Packages

Who Will Speak for Me?
DVD and Reference Materials for Child Law Practitioners
Who Will Speak for Me? gives a voice to the children caught in the child protection system. The video asks children to tell us how we might best provide legal representation to them, and presents their views and suggestions to enable us to better the level of services we provide. This video is an important learning tool for all attorneys who represent children, and is accompanied by extensive reference materials.(2004)

I Will Speak Up for Myself (1)
Legal Rights in Foster Care
DVD and Q & A Book for Children in Foster Care and Child Law Practitioners
I Will Speak Up for Myself is the children's answer to the tangle of legal issues they face in foster care. Narrated by youth in DCF care, the video discusses ways to resolve issues that affect foster children, empowering them to speak up for themselves to secure the services they need. The package includes the DVD, a question and answer book on the legal rights of children in foster care (including legal citations), and an 'Important Numbers' contact card for each child to personalize.(2004)

I Will Speak Up for Myself (2)
Legal Rights in Shelters, Group Homes, STAR Homes, and Residential Treatment Facilities
DVD and Q & A Book for Youth in Emergency Placement, and Child Law Practitioners
This important book helps children and youth answer questions about their legal rights in shelters, group homes, STAR homes and residential treatment facilities. Narrated by teens, the video reviews legal issues that affect this population, and suggests ways to resolve the problems they may face and secure needed services. The package includes the DVD, a question and answer legal rights book (including legal citations), and an 'Important Numbers' contact card for each child to personalize.(2008)

To Order

To order other publications from the Center for Children's Advocacy, or for additional copies of Adolescent Health Care, please use the order form on our website: *www.kidscounsel.org* and click on "CCA Publications" or call 860-570-5327.

Center for Children's Advocacy
Medical Legal Partnership Project
65 Elizabeth Street, Hartford, CT 06105

860-570-5327
www.kidscounsel.org