Sharing Health Information for Children in Foster Care

JUDICIAL COUNCIL BRIEFING ON INFORMATION SHARING

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I. INTRODUCTION

Individuals responsible for children in foster care, including placing agencies, caregivers and the courts, often need access to information in the children's health records to ensure appropriate care is provided and make informed decisions on the child's behalf. Yet, these health records also contain sensitive information and are protected by confidentiality laws. Confidentiality is a central legal and ethical tenet of health care, helping ensure patients feel safe seeking care and receive appropriate diagnoses and treatment. The applicable confidentiality laws allow for the disclosure of needed information in the child welfare context, but confusion about the application of these laws sometimes prevents appropriate and balanced disclosure. Children in foster care risk having their health care interrupted or delayed when too little or too much information is disclosed to stakeholders.

A priority for the Judicial Council is to identify and remove barriers that prevent children in foster care from getting the health care they deserve and that prevent child welfare services, caregivers, and the juvenile courts from obtaining the information they need to make informed decisions for children in foster care. One such barrier is confusion regarding applicable confidentiality law. The Judicial Council has prepared this overview of laws related to confidentiality and disclosure of medical information to address this concern. This overview is **not an exhaustive legal analysis** of all issues related to sharing health information concerning children in foster care. Rather, it is intended to provide a basis and catalyst for discussions between agencies, professionals and legal counsel about supporting access to care, collaborating across agencies, and identifying ways to ensure key stakeholders obtain the information they need to meet their obligations and make informed decisions for children in foster care while still honoring the core principle of confidentiality. The information in this brief applies to both dependent and juvenile justice involved children who are placed in foster or group care settings.

II. FEDERAL AND STATE LAWS

A. LAWS THAT REQUIRE CHILD WELFARE AGENCIES TO MAINTAIN MEDICAL INFORMATION IN EACH CHILD'S CASE PLAN AND PROVIDE THAT INFORMATION TO SPECIFIED INDIVIDUALS AND ENTITIES

- Title IV-E of the Social Security Act (42 U.S.C. § 670 et seq.) requires states to develop case plans for children in foster care, including the most recent information available regarding the child's health providers, immunization records, medications and any other relevant health information as determined by the child welfare agency. (42 U.S.C. §§ 671(a)(16), 675(1)(C).) Title IV-E also requires states to develop, in consultation with health experts, a plan for ongoing oversight and coordination of health and mental health care services, including the appropriate sharing of medical and mental health information. (42 U.S.C. § 622(b)(15)(A).)

- State law requires a case plan to include a summary of the child's health information and records. This summary must include the child's known medical problems, current medications, past health problems, hospitalizations, and any other relevant dental and health information. (*See* Welf. & Inst. Code, § 16010(a)(1); *see also* Welf. & Inst. Code, § 16501.16.)

- State law requires the child welfare agency to attach the health summary to each court report, which must be filed with the court at the initial hearing and all review hearings. (Welf. & Inst. Code, §§ 16010(b), 16501.1(g)(14).) For non-minor dependents, this summary is only included in the court report with written consent from the dependent. (Welf. & Inst. Code, § 16010(b).)

- State law requires the child welfare placing agency to provide a caretaker with a copy of the child's current health and education summary, (Welf. & Inst. Code, § 16010(c)), as well as medical and treatment information about foster youth in their care. (Welf. & Inst. Code, § 16010.5(a); *see* Welf. & Inst. Code, § 16010.1(j).)

B. LAWS THAT PROTECT THE PRIVACY AND CONTROL RELEASE OF HEALTH INFORMATION

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY RULE

- "Covered entities" must comply with HIPAA regulations regarding confidentiality and release of health information. "Covered entities" include health plans, health care clearinghouses, and health care providers who transmit health information in electronic form related to certain types of transactions. (45 C.F.R. § 160.103.) The "business associates" of covered entities also must follow HIPAA regulations in some cases. (45 C.F.R. § 160.103.) It is extremely unusual for a child welfare agency to qualify as a "covered entity" or to receive information as the "business associate" of a covered entity.

- The HIPAA Privacy Rule restricts covered entities from disclosing "protected health information" (PHI) unless a signed "authorization" permits the disclosure or an exception in HIPAA allows or requires the release. (45 C.F.R. §§ 164.502(a)(1), 164.508(a)(1).) "Protected health information" is individually identifiable health information in any form, including oral communications as well as written or electronically transmitted information. (45 C.F.R. § 160.103.)

- An authorization form must be written and contain specific elements and advisements to be valid. (45 C.F.R. § 164.508(c).) Adults and emancipated minors sign their own authorization form as long as they have authority to make health decisions for themselves. HIPAA defers to state law to define who signs an authorization on behalf of an unemancipated minor. (45 C.F.R. § 164.502(g).)

- Covered entities may disclose PHI without need of a signed authorization in a number of circumstances. For example, covered entities may make any disclosures required by a state

or federal law, such as to comply with mandated public health or child abuse reporting requirements. (45 C.F.R. § 164.512(a).) Covered entities also may comply with disclosures required by subpoena or court order. (45 C.F.R. § 164.512(e).) In addition, the Rule allows for disclosures for treatment, payment and health care operations, among other exceptions. (45 C.F.R. §§ 164.502(a)(1)(ii), 164.512.)

- Federal privacy regulations under HIPAA usually supersede any applicable state laws; however, if applicable state confidentiality law is more protective of individual privacy, then HIPAA directs covered entities to follow the state law. (45 C.F.R. §§ 160.203(b), 164.202.)

THE CALIFORNIA CONFIDENTIALITY OF MEDICAL INFORMATION ACT (CMIA)

- In general, CMIA parallels HIPAA, but it is more protective of individual privacy in some cases. A covered entity must comply with CMIA in those cases and attempt to comply with both whenever possible.

- CMIA controls the release of "medical information" by "providers of health care." "Medical information" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. (Civ. Code, § 56.05(j), (m)).

- In many cases, an individual or agency that receives medical information from a health provider is prohibited from further disclosing the information unless that disclosure also complies with CMIA. (Civ. Code, § 56.13.)

- CMIA states that providers of health care can disclose information protected by CMIA if there is a signed authorization or an exception in CMIA allows or requires the disclosure. (Civ. Code, §§ 56.10(a), 56.11.)

- To comply with CMIA, an authorization form must include certain elements and advisements to be valid. (Civ. Code, § 56.11.) CMIA requires an authorization to include elements not required by HIPAA. A form must include the elements and advisements required by both CMIA and HIPAA to be valid. See **Section VII** for a link to an example of a compliant form.

- Patients 18 years of age or older sign their own authorization form unless they have been found not to be competent to make medical decisions for themselves.

- For minors under age 18, the minor signs the authorization if the authorization is to release information related to services the minor consented to or could have consented to. State law authorizes minors to consent to their own health care in a number of situations. For example, a minor may consent to pregnancy related care at any age and starting at age 12, to substance use treatment. (Fam. Code, §§ 6924–6930; Health & Saf. Code, § 124260.) See **Section VII** for a link to a chart that lists all health care that minors may consent to in California.

- If a minor is not authorized to sign their own form, the minor's "legal representative" signs. (Civ. Code, § 56.11(c).) A parent or guardian is typically the minor's legal representative and retains the right to sign an authorization to release medical information though the juvenile court does have the authority to remove that right. (*See* Welf. & Inst. Code, § 361(a).)

- A recipient of information pursuant to an authorization form may not further disclose the information except in accordance with CMIA. (Civ. Code, § 56.13.)

- CMIA *requires* health care providers to disclose protected information in certain circumstances. For example, health care providers must disclose if the disclosure is required by a court order or a subpoena or specifically required by law. (Civ. Code, § 56.10(a), (b)(1) & (3).) Health providers also must disclose when the disclosure is specifically required by law. (Civ. Code, § 56.10(a), (b)(1), (3) & (9).) There are other required disclosures. (*See* Civ. Code, § 56.10(a), (b).)

- CMIA also *allows* health care providers to disclose protected information without need of a signed authorization in a number of circumstances. (Civ. Code, § 56.10(a), (c).) A recipient of information pursuant to one of these exceptions may not further disclose the information except in accordance with CMIA. (Civ. Code, § 56.13.)

THE CALIFORNIA EVIDENCE CODE

- California law gives patients the "privilege" to refuse to disclose and to prevent their health providers from disclosing "confidential communications" for use as evidence in court, even if the disclosure is otherwise authorized by HIPAA or CMIA. (Evid. Code, § 994.)

- "Confidential communications" between a patient and a doctor are information, including information obtained by an examination of the patient, transmitted between a patient and his physician in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the physician is consulted. This includes a diagnosis made and the advice given by the physician in the course of that relationship. (Evid. Code, § 992.)

- When a health provider is asked to disclose information that may be used as evidence in court, the provider is required to claim privilege on behalf of their patient unless they know privilege has been waived. (Evid. Code, §§ 995, 994(c).)

- In dependency cases, privilege may be waived by the child if they are of sufficient age and maturity, and in other cases, by the child's attorney. A child is presumed of sufficient age and maturity to invoke or waive privilege at age 12. Neither the Court nor a parent may waive privilege for a dependent child. (Welf. & Inst. Code, § 317(f).)

- There are a limited number of exceptions to privilege. (*See, e.g.*, Evid. Code, §§ 1016, 1024, 1027.) While there is a patient-litigant exception (Evid. Code, § 1016), this exception does not apply simply because medical information is introduced as part of a dependency petition or to demonstrate eligibility requirements for foster care. (*See N.S. v. Superior Court* (2016) 7 Cal.App.5th 713; *see also Karen P. v. Superior Court* (2011) 200 Cal.App.4th 908 and *In re M.L.* (2012) 210 Cal.App.4th 1457.)

- Addressing psychotherapist-patient privilege in the dependency and delinquency court context, courts have held that even where psychotherapist-patient privilege applies, certain circumscribed mental health information nevertheless may be included in reports submitted to Court from the child welfare or probation agency when reasonably necessary for a juvenile court to make decisions regarding custody, visitation, services and other aspects of the case plan; however the extent of the information that may be included in a court report without violating privilege will vary based on the specifics of the case. There is extensive case law in this area that should be reviewed to understand the current state of the law and scope of privilege. (*See In re Pedro M.* (2000) 81 Cal.App.4th 550; *In re Kristine W.* (2001) 94 Cal.App.4th 521; *In re Mark L.* (2001) 94 Cal.App.4th 573; and subsequent cases.)

III. WHEN HEALTH PROVIDERS MAY AND MUST SHARE INFORMATION

This section provides a few examples and should not be considered an exhaustive list.

A. MAY, AND SOMETIMES MUST, SHARE SOME HEALTH INFORMATION OF MINORS WHO ARE DEPENDENTS OR WARDS WITH PARENTS, GUARDIANS, AND CAREGIVERS, WITH A FEW EXCEPTIONS

- Under HIPAA and CMIA, a parent or legal guardian generally has access to information on the minor patient's condition and care (Health & Saf. Code, § 123110(a)), except when:

  - The minor consented or could have consented for the underlying health care;
  - The court has removed the right to access records from the parents; or
  - The health care provider determines that access to the records would have a detrimental effect on the provider's professional relationship with the minor or the minor's physical safety or psychological well-being.

  (45 C.F.R. § 164.502(g); Civ. Code, § 56.10(b)(7); Health & Saf. Code, §§ 123110(a), 123115(a), (b); Welf. & Inst. Code, § 361(a).) See **Section VII** for a link to a chart with information on services minors may consent to on their own behalf.

- For caregivers, HIPAA and CMIA allow a health provider to disclose medical information, without need of an authorization, to "any other person who is legally authorized to have custody or care of a minor" if the disclosure is for the purpose of coordinating health care services and medical treatment (Civ. Code, §§ 56.10(c)(20), 56.103), except caregivers cannot access the following information under this exception:

- Psychotherapy notes or
- Information related to treatment that the minor consented to or could have consented to on their own behalf.

(Civ. Code, § 56.103(e), (h)(2).) For purposes of this section, "minor" means "a minor taken into temporary custody or as to whom a petition has been filed with the court, or who has been adjudged to be a dependent child or ward of the juvenile court pursuant to Section 300 or 601 of the Welfare and Institutions Code." (Civ. Code, § 56.103(g).)

A caregiver who receives information under this exception cannot use the information for purposes other than coordination of services and treatment. They also cannot further disclose the information unless the disclosure is for the purpose of coordinating health care services and medical treatment of the minor and the disclosure is authorized by law. Health information disclosed pursuant to this section also cannot be admitted into evidence in any criminal or delinquency proceeding against the minor. (Civ. Code, §§ 56.103(d), 56.13.)

B. MUST SHARE HEALTH INFORMATION WITH MINOR'S DEPENDENCY COUNSEL

- Counsel for a dependent child has a right to access the child's medical records. (Welf. & Inst. Code, § 317(f).)

C. MAY SHARE HEALTH INFORMATION OF YOUTH WHO ARE DEPENDENTS OR WARDS WITH OTHER HEALTH CARE PROVIDERS FOR PURPOSES OF REFERRAL AND PROVISION OF CARE

- Providers may share protected health information with other providers of health care, health care service plans, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient, without need of an authorization or court order. (45 C.F.R. § 164.502(a)(1)(ii); Civ. Code, § 56.10(c)(1).) The provider who receives this information must comply with HIPAA and CMIA regarding any further disclosures of the information. (Civ. Code, § 56.13.)

D. MAY SHARE CERTAIN HEALTH INFORMATION OF YOUTH WHO ARE DEPENDENTS OR WARDS WITH THE CHILD WELFARE, PROBATION, CASEWORKERS, AND FOSTER CARE PUBLIC HEALTH NURSES

HIPAA and state law allow health providers to share health information with agencies and caseworkers through different mechanisms. Depending on the mechanism used, there may be limits on the purposes for which the agency may use the information, as well as limits on the agency's ability to re-disclose the information to third parties or use it in court proceedings.

- Health care providers must release information to child welfare and probation agencies pursuant to a signed authorization that complies with HIPAA and CMIA. (Civ. Code, §§ 56.10(a), 56.11.) There may be limits on the agency's ability to re-disclose this

information if the authorization does not authorize re-disclosures (Civ. Code, § 56.13) or use it as evidence in court if privilege has not been waived.

- Health care providers must release information to agencies pursuant to a valid court order requiring release to the agency. (Civ. Code, § 56.10(a), (b)(1) & (3).) There may be limits on the agency's ability to use it as evidence in court absent a waiver of privilege.

- HIPAA and CMIA allow a health provider to disclose medical information, without need of an authorization, to a county social worker, probation officer or foster care public health nurse for the purpose of coordinating health care services and medical treatment for a minor (Civ. Code, §§ 56.10(c)(20), 56.103), except they cannot disclose under this exception:

  - Psychotherapy notes or
  - Information related to treatment that the minor consented to or could have consented to on their own behalf.

  (Civ. Code, § 56.103(e), (h)(2).) For purposes of this section, "minor" means "a minor taken into temporary custody or as to whom a petition has been filed with the court, or who has been adjudged to be a dependent child or ward of the juvenile court pursuant to Section 300 or 601 of the Welfare and Institutions Code." (Civ. Code, § 56.103(g).)

  Professionals who receive information under this exception cannot use the information for purposes other than coordination of services and treatment. They also cannot further disclose the information unless the disclosure is for the purpose of coordinating health care services and treatment of the minor and the disclosure is authorized by law. Health information disclosed pursuant to this section also cannot be admitted into evidence in any criminal or delinquency proceeding against the minor. (Civ. Code, § 56.103(d).)

E. MAY DISCLOSE INFORMATION TO MEMBERS OF CHILD AND FAMILY TEAMS AND MULTIDISCIPLINARY TEAMS WITH THE APPROPRIATE DOCUMENTATION IN PLACE

State law requires use of child and family teams (CFTs) by child welfare and probation and authorizes the creation of several types of multidisciplinary teams (MDTs) to better address child welfare needs. Health providers may be invited to participate in such teams and can play an important role.

CHILD AND FAMILY TEAMS

- Section 16501 of the Welfare and Institutions Code requires child welfare and probation to engage and consider the recommendations of "child and family teams" as part of child welfare service provision. (Welf. & Inst. Code, §§ 16501(a), 706.5, 706.6.) "Child and family team" for this purpose is defined as "a group of individuals who are convened by the placing agency and who are engaged through a variety of team-based processes to identify the strengths and needs of the child or youth and his or her family, and to help achieve positive outcomes for safety, permanency, and well-being." (Welf. & Inst. Code, § 16501(a).)

- Section 832 of the Welfare and Institutions Code addresses sharing of information and records among members of a 16501 "child and family team."

- Health care providers who are members of CFTs may receive information from other members of the CFT. (Welf. & Inst. Code, § 832(a)(1).)

- Health care providers must release information to the CFT pursuant to a valid court order requiring release. (Civ. Code, § 56.10(a), (b)(1) & (3).)

- Health providers may disclose protected health information to other members of the CFT if a written authorization that complies with CMIA and HIPAA authorizes such disclosure, and a waiver of privilege is in place as necessary. (Civ. Code, § 56.10(a); Welf. & Inst. Code, § 832(a)(1), (b) & (c).) Section 832 requires the child and family team to obtain the appropriate authorizations to release information to team members. (Welf. & Inst. Code, § 832(b)(2).)

- Once a valid authorization is in place, "relevant information and records may be shared with members of the team." However, if the team determines that the disclosure of information would present a reasonable risk of a significant adverse or detrimental effect on the child's or youth's psychological or physical safety, the information shall not be released. (Welf. & Inst. Code, § 832(c).)

- "Disclosure of otherwise privileged information to team members shall not be construed to waive the privilege." (Welf. & Inst. Code, § 832(g).)

- Information exchanged among CFT members shall be received in confidence for the limited purpose of providing necessary services and support to the child or youth and family. (Welf. & Inst. Code, § 832(a)(2).)

- Information shared with members of a CFT is subject to confidentiality and re-disclosure limitations:

    - "Information and records communicated or provided to the team, by all providers, programs, and agencies, as well as information and records created by the team in the course of serving its children, youth, and their families, shall be deemed private and confidential and shall be protected from discovery and disclosure by all applicable statutory and common law. Nothing in this section shall be construed to affect the authority of a health care provider to disclose medical information pursuant to paragraph (1) of subdivision (c) of Section 56.10 of the Civil Code." (Welf. & Inst. Code, § 832(d).)

- "All discussions during team meetings are confidential unless disclosure is required by law. Notwithstanding any other law, testimony concerning any team meeting discussion is not admissible in any criminal or civil proceeding." (Welf. & Inst. Code, § 832(a), (f).)

- By July 1, 2021, the Department of Social Services must issue written instructions to counties that describe all protections provided by statute for the confidentiality of mental health, reproductive and sexual health, and minor drug treatment information concerning minors and nonminor dependents for whom a child and family team meeting is held, including, but not limited to, the duties of therapists not to disclose confidential information, as described in Sections 123115 and 123116 of the Health and Safety Code and Section 1015 of the Evidence Code. (Welf. & Inst. Code, § 832(g).)

MULTIDISCIPLINARY TEAMS

State laws authorize and encourage creation of several types of MDTs in the child welfare and probation context to further collaboration and coordination. Here are two examples:

- **Section 18951** authorizes the creation of an MDT defined as "any team of three or more persons who are trained in the prevention, identification, management, or treatment of child abuse or neglect cases and who are qualified to provide a broad range of services related to child abuse or neglect." Health care providers may be invited to participate. (Welf. & Inst. Code, §§ 18951(d), 18964.)

- In general, members of the MDT "may disclose and exchange information and writings to and with one another relating to any incidents of child abuse that may also be a part of a juvenile court record or otherwise designated as confidential under state law if the member of the team having that information or writing reasonably believes it is generally relevant to the prevention, identification, management, or treatment of child abuse, or the provision of child welfare services" as described below. (Welf. & Inst. Code, § 830(a).)

- Health care providers who are members of the "18951 MDT" may receive information from other members of the MDT. (Welf. & Inst. Code, § 830(a).)

- Health providers may disclose protected health information "relating to any incidents of child abuse" to other members of the 18951 MDT if a written authorization that complies with CMIA and HIPAA authorizes such disclosure and a waiver of privilege is in place as necessary. (Civ. Code, § 10(a), (b)(1) & (3).) Members of the MDT must comply with CMIA and Evidence code regarding further disclosure of health information disclosed in an MDT meeting. "Notwithstanding any other provision of law, testimony concerning any such discussion is not admissible in any criminal, civil, or juvenile court proceeding." (Welf. & Inst. Code, § 830(a).)

- **Section 18961.7** authorizes a county to create an MDT "to allow provider agencies to share confidential information in order for provider agencies to investigate reports of suspected child abuse or neglect made pursuant to Section 11160, 11166, or 11166.05 of the Penal Code, or for the purpose of child welfare agencies making a detention determination." (Welf. & Inst. Code, § 18961.7(a).) An "18961.7 MDT" can be "any team of two or more persons who are trained in the prevention, identification, or treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child

abuse." Health providers may be invited to participate. (Welf. & Inst. Code, § 18961.7(b)(1).)

- Health providers who are members of an 18961.7 MDT may receive information from other members of the MDT.

- Health providers may disclose protected health information to other members of the 18961.7 MDT if a written authorization that complies with CMIA and HIPAA authorizes such disclosure and a waiver of privilege is in place as necessary. (Civ. Code, § 10(a), (b)(1) & (3).) Members of the MDT must comply with CMIA and Evidence code regarding further disclosure of health information pursuant to the authorization.

- It is unclear whether a health care provider may share information protected by HIPAA and CMIA with an MDT absent a written authorization. Section 18961.7 states that notwithstanding any other law, during a 30-day period following a report of suspected abuse, and longer if documented good cause exists, health providers who are members of the 18961.7 MDT may disclose information designated as confidential under state law to other members of the MDT if the information is related to an incident of child abuse and the health provider reasonably believes it is generally relevant to the prevention, identification, or treatment of child abuse. (Welf. & Inst. Code, § 18961.7(c).) However, subdivision (g) says, "This section shall not be construed to restrict guarantees of confidentiality provided under state or federal law." Further guidance on how to interpret the interplay of subdivisions (c) and (g) and application of HIPAA and CMIA would be helpful.

- There are restrictions on re-disclosure of information shared with an 18961.7 MDT. The information and records communicated or provided to 18961.7 team members, as well as information and records created, "shall be deemed private and confidential and shall be protected from discovery and disclosure by all applicable statutory and common law protections. Existing civil and criminal penalties shall apply to the inappropriate disclosure of information held by the team members." (Welf. & Inst. Code, § 18961.7(h).)

IV. CHILD WELFARE AND PROBATION MAY SHARE CERTAIN HEALTH INFORMATION WITH THE COURT, BUT DISCLOSURE MAY BE LIMITED BY THE CHILD'S PHYSICIAN-PATIENT PRIVILEGE

- California law requires the child welfare agency to maintain a health summary for foster children and to include this summary in court reports. (Welf. & Inst. Code, §§ 16010(a), 16501.1(g)(14).)

- In general, summary health information provided in court reports cannot include privileged communications unless the child or child's attorney waives the privilege. (Evid. Code, § 994.) However, even when privilege applies, courts have held that circumscribed information that is reasonably necessary for a court to make decisions regarding custody, visitation, services and other aspects of the case plan may enter as evidence. *See* section II(B), "The California Evidence Code", *infra*, for more information.

- Ultimately, though, a case worker may have access to information for other purposes that the social worker cannot disclose in court reports because the information constitutes a privileged communication between the child and a doctor.

V. FEDERAL LAW ENCOURAGES AUTOMATED DATA EXCHANGES OF HEALTH CARE INFORMATION BETWEEN THE MEDICAID AGENCY, THE CHILD WELFARE AGENCY AND THE COURTS

- Federal regulations require state child welfare agencies to maintain certain data electronically and have electronic data systems that support exchange of information in a way that complies with confidentiality laws. (45 § C.F.R. §§ 1355.40, 1355.43, 1355.52, 1355.53.)

- Federal law encourages states to develop child welfare automated systems that have the capability for automated data exchanges between the child welfare agency and agencies such as the Medicaid agency, and the courts among others. The system must support bidirectional data exchange with certain partners. (45 C.F.R. § 1355.52(e).)

VI. CONCLUSION

Children in foster care have a right to health care and to have their health needs met. Meeting their health needs requires access to certain information. Title IV-E requires case plans for all children in foster care, and requires that these case plans include essential health information. California must comply with the federal plan requirements in order to receive federal funding for child welfare services and the foster care program.

Stakeholders must treat health information with sensitivity and need a clear understanding of the confidentiality protections accorded health records as required by law. However, within these parameters, certain health information for foster children can be shared among courts, health providers, probation, caregivers, and the child welfare agency in order to satisfy their case plan obligations and, most importantly, meet the health needs of the child.

VII. ADDITIONAL RESOURCES

From the California Department of Social Services:

- All County Information Letter No. 1-06-20, *New Resources for Case management Workers for Documenting, Protecting and Sharing Reproductive and Sexual Health Information for Youth and Non-Minor Dependents (NMDs) in Foster Care (January 27, 2020),* https://mcusercontent.com/73901133dd7ea1a5581344daf/files/73cc7faa-8855-4060-8e84-2a0f53928104/I_06_20.pdf

- All County Letter No. 18-23, *The Child and Family Team (CFT) Process Frequently Asked Questions and Answers* (June 1, 2018), *www.cdss.ca.gov/Portals/9/ACL/2018/18-23.pdf?ver=2018-06-01-160245-447*.

- The Health Care Program for Children in Foster Care (HCPCFC), https://www.dhcs.ca.gov/services/HCPCFC/Pages/ProgramOverview.aspx

From the Judicial Council:

- *Authorization to Release Health Information* (form JV-226), *www.courts.ca.gov/documents/jv226.pdf*.

From other sources:

- National Center for Youth Law, *California Minor Consent and Confidentiality Laws* (Nov. 2018), *http://teenhealthlaw.org/wp-content/uploads/2019/08/2019CaMinorConsentConfChartFull.pdf*.

- National Center for Youth Law, *Consent to Treatment for Probation Youth – By Custody and Placement* (Oct. 2018), *http://teenhealthlaw.org/wp-content/uploads/2015/11/Del-ConsentbyCustodychart10-2018.pdf*

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