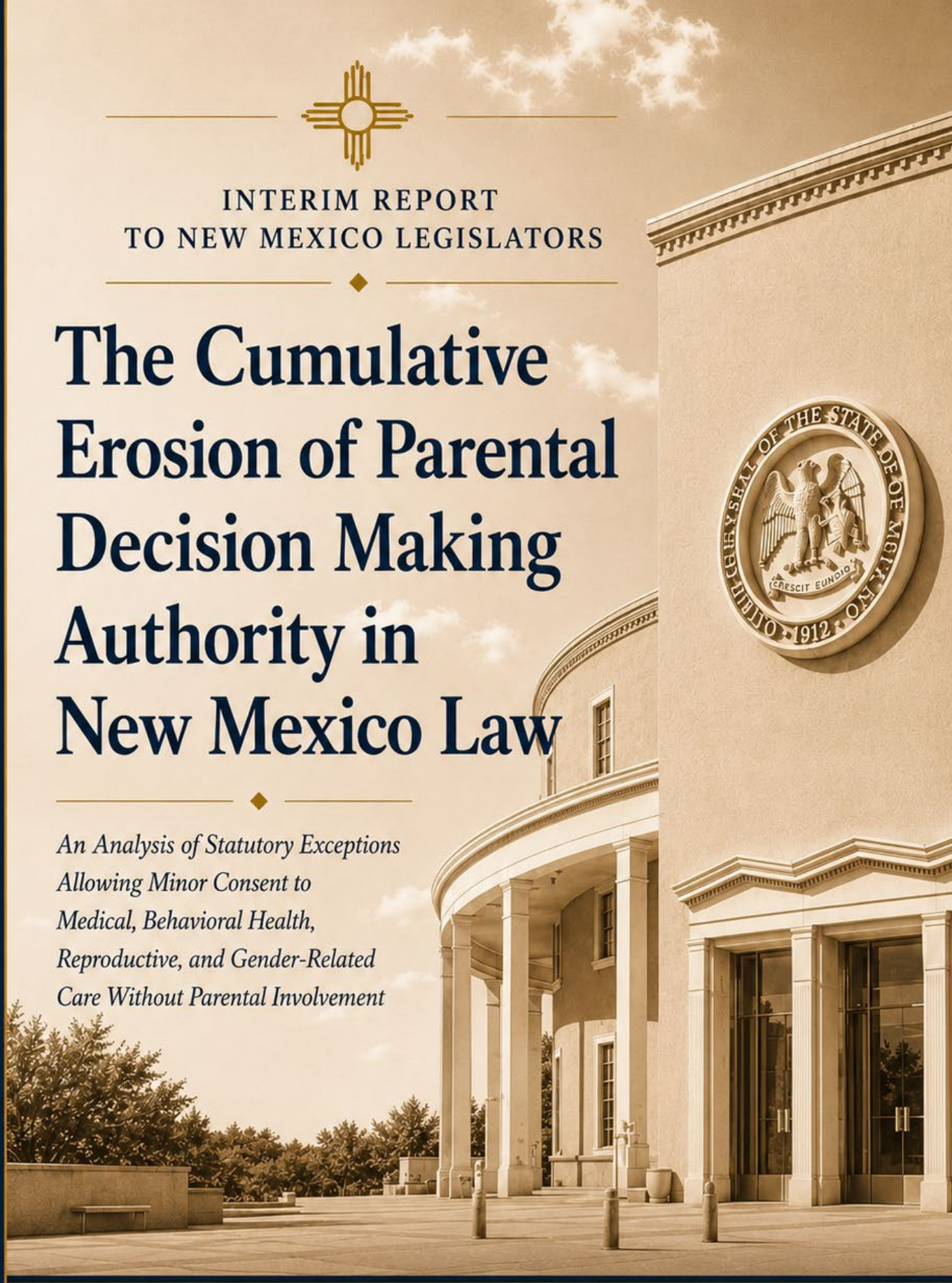
INTERIM REPORT
TO NEW MEXICO LEGISLATORS

The Cumulative Erosion of Parental Decision Making Authority in New Mexico Law

An Analysis of Statutory Exceptions Allowing Minor Consent to Medical, Behavioral Health, Reproductive, and Gender-Related Care Without Parental Involvement



PREPARED FOR THE
HOUSE REPUBLICAN CAUCUS

2026

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EXECUTIVE SUMMARY

For generations, American law has recognized that parents—not the government—bear the primary responsibility for raising, educating, protecting, and guiding their children. The United States Supreme Court has repeatedly affirmed that the rights of parents to direct the upbringing of their children are among the oldest and most fundamental liberty interests protected by the Constitution. These rights include decisions relating to education, healthcare, religious instruction, and the moral formation of children.

Yet many New Mexico families now find themselves confronting a legal and cultural landscape that looks dramatically different from the one that existed only a generation ago. Over many years, low civic participation, voter disengagement, and political apathy – particularly among conservatives, parents, and people of faith – have allowed increasingly progressive policies to take root in New Mexico state government with relatively little public scrutiny or resistance. Incrementally and often quietly, the Legislature has enacted laws that shift authority away from parents and families and toward minors, schools, healthcare providers, and government institutions.

Consistent with longstanding constitutional principles, American law has traditionally treated the age of eighteen as the clear dividing line between childhood and adulthood. Until reaching that age, parents have historically served as the primary decision-makers responsible for helping children navigate matters carrying serious physical, emotional, psychological, and spiritual consequences.

In recent years, however, New Mexico has enacted a growing number of laws that depart from this traditional framework. These statutes authorize minors to independently consent to significant medical, behavioral health, reproductive, and other healthcare services without parental consent and, in many cases, without parental knowledge. While many of these laws are presented as narrow exceptions designed to promote healthcare access or address public health concerns, their cumulative effect has been far broader.

Taken together, these statutes reflect a significant shift in New Mexico law away from parental authority and toward increasing minor autonomy, institutional control, and state involvement in decisions historically reserved to families. New Mexico law no longer treats eighteen as a firm and consistent boundary between parental authority and minor independence. Instead, it creates a patchwork system in which children may independently make consequential decisions in discrete areas of their lives while parents are often excluded from meaningful participation.

Compounding these concerns, state and federal confidentiality laws frequently prevent parents from accessing records and information related to services obtained by minors. Once a child independently consents to treatment, parents may be denied access to counseling records, behavioral health information, reproductive healthcare records, substance abuse treatment information, and other sensitive medical communications. In practice, parents may remain legally and financially responsible for their children while simultaneously being excluded from major decisions affecting their child's health and well-being.

Many New Mexico parents and faith communities are increasingly concerned that schools, counselors, healthcare providers, and government institutions are assuming expanding roles in matters involving sexuality, gender identity, behavioral health, and moral development while parental authority continues to diminish. These concerns extend beyond politics and implicate

fundamental questions about family autonomy, religious liberty, and the proper role of government in the lives of children.

This report examines the principal New Mexico statutes that authorize minors to make independent healthcare decisions and the confidentiality laws that frequently shield those decisions from parental involvement. It further explores how these laws, viewed collectively, represent a substantial erosion of traditional parental authority and a significant transformation in the relationship between parents, children, healthcare providers, schools, and the state.

Ultimately, the purpose of this report is not merely to catalog statutes, but to inform parents, churches, community leaders, and policymakers about the direction of New Mexico law and the broader consequences these policies may have for families and the family unit itself. Laws governing parental rights, education, healthcare, and confidentiality are shaped through elections, legislation, administrative policies, and judicial decisions. The legal framework examined in this report did not emerge overnight; it developed gradually through years of political disengagement and limited public involvement.

If parents and people of faith wish to preserve the longstanding principle that parents – not the state – should remain the primary guides and decision-makers in the lives of their children, civic engagement is no longer optional. Voting, participating in local elections, engaging with school boards, monitoring legislation, and remaining active in public life have become essential responsibilities for families concerned about the future direction of New Mexico and the preservation of parental rights.

STATE STATUTORY FRAMEWORK GOVERNING MINOR CONSENT TO MEDICAL CARE

The constitutional principles outlined above are reflected – and, in important respects, limited – by a series of statutory enactments that define when and under what circumstances a minor may consent to medical care without parental involvement. Rather than adopting a single uniform rule, the New Mexico Legislature has established a growing collection of targeted statutory exceptions authorizing minors to make independent health care decisions in specific contexts.

These statutes vary in scope and application. Some confer broad authority based on a minor's status or living situation, while others apply to particular categories of care, including behavioral health services, reproductive health care, and public health treatment. Still others operate in limited or emergency circumstances. While each provision is often presented as a narrow exception to the general rule requiring parental consent, the cumulative effect of these enactments has been to steadily weaken the presumption that parents should remain the primary decision-makers in matters affecting their children's physical and emotional well-being.

Underlying these statutes is an increasingly prominent policy assumption that, in certain circumstances, the state or medical provider may be better positioned than parents to determine what is in a child's best interests. This represents a marked departure from the longstanding legal and cultural tradition recognizing the family – not the government – as the primary institution responsible for raising children and safeguarding their welfare.

The following sections outline the principal statutory provisions that permit minors to consent to their own medical care in New Mexico and examine the scope and implications of each.

I. Broad Grants of Medical Decision-Making Authority

New Mexico law includes a number of statutory provisions that confer broad medical decision-making authority on certain categories of minors based upon their status or circumstances rather than the specific type of care at issue. Unlike more narrowly tailored statutes that apply only to discrete categories of treatment, these provisions authorize qualifying minors to consent to general medical care without parental involvement or approval. In doing so, they represent some of the most significant departures from the traditional principle that parents retain primary authority over their children's medical care.

These statutes apply to minors whom the Legislature has determined possess sufficient independence or maturity to make medical decisions on their own. In practice, however, they permit children who remain legally incapable of exercising most other adult rights and responsibilities to independently authorize potentially significant medical treatment without parental guidance or oversight.

By allowing qualifying minors to access broad categories of medical services without parental knowledge or consent, these provisions effectively create a class of minors who may exercise adult-like authority over critical health care decisions prior to reaching the age of majority. This shift carries profound implications not only for parental rights, but also for the broader principle that parents bear the primary responsibility for protecting the physical, emotional, and moral well-being of their children.

The following provisions illustrate the scope and operation of these broad grants of authority.

Consent Based Upon Minor Status

New Mexico law grants certain minors the legal authority to consent to broad categories of medical care based not upon the nature of the treatment sought, but upon the minor's personal status or circumstances. Under these provisions, the Legislature has determined that specific categories of minors should, for purposes of medical decision-making, be treated in a manner substantially similar to adults. These statutes therefore represent some of the broadest exceptions to the traditional rule that parents retain primary authority over the medical care of their children.

Historically, the law has recognized limited circumstances in which a minor assumes adult responsibilities at an earlier age, such as through marriage, military service, or legal emancipation. In those situations, legislatures and courts have often concluded that the assumption of adult obligations justifies the conferral of certain adult legal rights. New Mexico law follows this traditional framework by granting emancipated and married minors the authority to independently consent to medical treatment without parental involvement.

In recent years, however, the Legislature has expanded these concepts beyond traditional emancipation doctrines. Current law now authorizes additional categories of minors, including unemancipated minors as young as 14 years old who are living apart from their parents or who themselves have children, to independently consent to broad categories of medically necessary healthcare. These statutes permit qualifying minors to obtain physical, mental, and behavioral health services without parental knowledge or approval and expressly prohibit the minor's consent from being invalidated on the basis of age alone.

Importantly, these provisions do more than merely recognize practical realities involving independent or vulnerable minors. They also reflect a broader policy shift away from the longstanding presumption that parents should remain the primary decision-makers for their children absent extraordinary circumstances. In doing so, the law increasingly treats certain minors as possessing adult-like autonomy in matters carrying potentially significant physical, emotional, and long-term consequences, while simultaneously reducing the role of parents in guiding and overseeing those decisions.

The following statutory provisions illustrate the scope and operation of consent authority based upon minor status.

A. EMANCIPATED MINORS

Statutory Authority: §§ 24-10-1, 32A-21-3, 32A-21-5, and 24-7A-2

Summary. New Mexico law recognizes several circumstances in which a minor may attain legal status substantially equivalent to adulthood for purposes of medical decision-making. Under the Emancipation of Minors Act,[1] a minor over the age of 16 is considered emancipated if the minor:

- has entered into a valid marriage, regardless of whether the marriage is later dissolved;[2]
- is serving on active duty with the armed forces of the United States;[3] or

[1] Section 32A-21-1 through Section 32A-21-7 NMSA 1978
[2] Section 32A-21-3 (A) NMSA 1978.
[3] Section 32A-21-3 (B) NMSA 1978.

- has received a judicial declaration of emancipation pursuant to the Emancipation of Minors Act.[4]

Once emancipated, the minor is treated as having attained the age of majority for purposes of consenting to medical, dental, psychiatric, hospital, and surgical care.[5] The minor may independently authorize treatment without parental consent, knowledge, or involvement, and the validity of that consent may not later be challenged or invalidated on the basis of minority status. An emancipated minor is also able to execute a power of attorney for health care authorizing an agent to make any health care decisions on their behalf in case of incapacitation.[6]

Importantly, the law specifies that once emancipated status is attained through marriage, a later annulment or divorce does not restore the individual to minor status for purposes of medical decision-making authority. The adult legal capacity once conferred continues notwithstanding the termination of the marriage.

Implications for Parental Rights. Historically, emancipation statutes were understood as narrow exceptions to the general rule of parental authority, grounded in the recognition that certain minors had already assumed adult legal responsibilities and obligations. In such circumstances, the law viewed the conferral of corresponding adult rights, including authority over medical care, as a practical necessity.

Even within this traditional framework, however, emancipation provisions represent a significant legal departure from ordinary parental authority. Once emancipated, parents lose the ability to direct, oversee, or even necessarily receive information regarding the minor's medical treatment despite the minor remaining under the age of 18.

Although these statutes apply only to limited categories of minors, they establish the broader legal principle that the Legislature may separate medical decision-making authority from the age of majority itself. That principle has become increasingly important as New Mexico law has expanded independent consent authority into additional categories of minors who have not traditionally been viewed as possessing adult legal autonomy.

B. Married Minors

Statutory Authority: § 24-10-1, 32A-21-3, 32A-21-5, and 24-7A-2

Summary. New Mexico law provides that any minor who has entered into a lawful marriage is deemed legally capable of making their own health care decisions[7], including consenting to hospital, medical, and surgical care without parental involvement.[8] Once married, the minor may independently authorize medical treatment, and that consent may not later be invalidated or disaffirmed on the basis of the individual's minority status.[9] The statute further specifies that parental consent is not required to authorize such care.

[4] Section 32A-21-3 (C) NMSA 1978.
[5] Section 32A-21-5 (A) NMSA 1978.
[6] Section 24-7A-2 NMSA 1978.
[7] Section 24-7A-2 NMSA 1978.
[8] Section 24-10-1 NMSA 1978.
[9] Section 24-10-1 NMSA 1978.

In addition, the law provides that once adult status is attained through marriage, a subsequent annulment or dissolution of the marriage does not revoke the minor's authority to independently consent to medical treatment. The legal capacity conferred by marriage therefore continues even after the marital relationship has ended.

Implications for Parental Rights. The married minor exception reflects a longstanding legal principle that marriage historically carried with it adult legal responsibilities and obligations. Because married individuals were traditionally expected to establish independent households and assume responsibility for family and financial matters, the law correspondingly granted married minors the authority to make decisions regarding their own medical care.

At the same time, the statute represents a complete transfer of medical decision-making authority away from parents once the qualifying marital status exists. Parents no longer retain the ability to authorize treatment, direct care, or necessarily receive information concerning the minor's medical condition or treatment decisions despite the individual remaining under the age of 18.

Although the married minor provision arose from relatively narrow historical circumstances, it nevertheless illustrates an important feature of New Mexico's broader statutory framework governing minor consent: the Legislature has increasingly recognized circumstances in which legal adulthood, at least for medical purposes, may exist prior to the age of majority. This gradual separation between chronological age and legal decision-making authority forms part of the broader trend examined throughout this report.

C. Minor Living Apart from Parents or Legal Guardians

Statutory Authority: § *24-7-6.2*

Summary. New Mexico law authorizes certain unemancipated minors to independently consent to medically necessary health care based upon their living circumstances. An unemancipated minor who is at least 14 years old, possesses the capacity to consent, and is living apart from the minor's parents or legal guardian may consent to medically necessary health care without parental involvement.[10]

The statute defines "medically necessary healthcare" broadly to include essential clinical and rehabilitative physical, mental, and behavioral health services that are not primarily required for the convenience of the minor, health care provider, or payer.[11] Once the qualifying minor consents to treatment, that consent may not later be disaffirmed or invalidated on the basis of the minor's age.[12]

Statute further provides that parents or legal guardians are generally not financially liable for the cost of services provided pursuant to the minor's consent unless they separately consented to the care, or the care was rendered in an emergency.[13]

Implications for Parental Rights. Unlike traditional emancipation statutes tied to marriage, military service, or judicial findings of independence, this provision extends substantial medical decision-making authority to minors based primarily upon the fact that they are living apart from

[10] Section 24-7A-6.2 (A) NMSA 1978.
[11] Section 24-7A-6.2 (B) NMSA 1978.
[12] Section 24-7A-6.2 (C) NMSA 1978.
[13] Section 24-7A-6.2 (D) NMSA 1978.

their parents or legal guardians. The law does not require that the separation result from formal emancipation proceedings or any judicial determination permanently terminating parental authority. As a result, a 14-year-old minor who is temporarily or informally living apart from a parent may independently authorize broad categories of medical, mental, and behavioral health care without parental knowledge or approval.

The breadth of the statute is significant. By including physical, mental, and behavioral health care within the definition of medically necessary services, the provision potentially authorizes minors to independently access a wide range of treatments carrying substantial physical, emotional, and long-term consequences. At the same time, parents may be excluded from participation in treatment decisions despite retaining broader legal, moral, and practical responsibility for the child's welfare.

This provision reflects a broader shift in New Mexico law away from the traditional presumption that parents should remain the primary decision-makers for minors absent extraordinary circumstances. Rather than narrowly addressing emergency or temporary care needs, the statute effectively recognizes a category of unemancipated minors as possessing adult-like medical autonomy years before reaching the age of majority. For many families and community leaders, this raises significant concerns regarding the erosion of parental authority, the weakening of family involvement in health care decisions, and the increasing role of the state and medical providers in matters historically entrusted to parents.

D. Minor Who is a Parent of a Child

Statutory Authority: § 24-7A-6.2

Summary. New Mexico law also grants broad medical decision-making authority to certain unemancipated minors who are themselves parents. An unemancipated minor who is at least 14 years old, possesses the capacity to consent, and is a parent of a child may consent to medically necessary health care without parental involvement.[14]

The statute defines "medically necessary healthcare" broadly to include essential clinical and rehabilitative physical, mental, and behavioral health services that are not primarily required for the convenience of the minor, health care provider, or payer.[15] Once the qualifying minor consents to treatment, that consent may not later be disaffirmed or invalidated on the basis of the minor's age.[16]

The statute further provides that parents or legal guardians of the minor parent are generally not financially liable for the cost of services provided pursuant to the minor's consent unless they separately consented to the care, or the care was rendered in an emergency.[17]

Implications for Parental Rights. This provision reflects the Legislature's determination that a minor who has become a parent possesses sufficient maturity and independence to make health care decisions on his or her own behalf. Historically, the law has often recognized that the assumption of parental responsibilities carries with it corresponding legal authority and obligations. Nevertheless, the statute represents a substantial departure from the traditional

[14] Section 24-7A-6.2 (A) NMSA 1978.
[15] Section 24-7A-6.2 (B) NMSA 1978.
[16] Section 24-7A-6.2 (C) NMSA 1978.
[17] Section 24-7A-6.2 (D) NMSA 1978.

framework under which parents retain primary authority over the medical care of their minor children until the age of majority.

Notably, the statute confers broad authority over the minor parent's own physical, mental, and behavioral health care rather than limiting consent authority solely to matters relating to pregnancy or the care of the minor's child. As a result, a 14-year-old unemancipated minor who is the parent of a child may independently authorize a wide range of medical treatment without parental knowledge, participation, or oversight.

The law therefore creates a circumstance in which grandparents or legal guardians may continue to bear substantial practical responsibility for the well-being, housing, financial support, and stability of the minor while simultaneously being excluded from major health care decisions affecting that minor. For many families, this represents a significant weakening of the traditional family structure and parental role recognized throughout American legal history.

More broadly, this provision further illustrates the Legislature's increasing willingness to separate medical decision-making authority from the traditional age of majority. By extending adult-like autonomy to minors based upon personal circumstances rather than legal adulthood itself, New Mexico law continues to expand the categories of minors permitted to independently make consequential health care decisions without parental involvement.

Consent Based Upon the Nature of Services Rendered

In addition to granting consent authority based upon a minor's status or living circumstances, New Mexico law also authorizes minors to independently consent to specific categories of medical care based upon the nature of the services being provided. Under these provisions, the Legislature has determined that certain forms of treatment implicate public health concerns, privacy interests, emergency circumstances, or behavioral health considerations sufficient to justify limiting or eliminating parental involvement in medical decision-making.

Historically, many of these exceptions were narrowly confined to emergency situations in which immediate medical intervention was necessary to preserve life or prevent serious harm and parents could not reasonably be located. Such provisions were generally understood as practical and temporary departures from the ordinary rule of parental consent. Over time, however, New Mexico law has expanded well beyond traditional emergency exceptions and now permits minors to independently consent to a growing range of medical, behavioral, reproductive, and end-of-life services without parental knowledge or approval.

These statutes authorize minors to make decisions regarding mental health treatment, substance abuse services, sexually transmitted infections, HIV testing, contraception, pregnancy-related care, blood donation, and even, under certain circumstances, the withholding or withdrawal of life-sustaining treatment. In several instances, the law expressly grants minors confidentiality protections that limit parental access to medical records or participation in treatment decisions.

While many of these statutes are justified on the basis of protecting vulnerable youth or encouraging access to care, they collectively represent a substantial departure from the longstanding understanding that parents should remain the primary source of guidance, protection, and decision-making for their children during moments of physical, emotional, and moral vulnerability. Particularly in areas involving behavioral health, sexuality, reproductive

matters, and life-altering medical decisions, these provisions increasingly permit the state and medical providers to operate independently of the family unit.

The expansion of service-based consent authority reflects a broader philosophical shift in the relationship between parents, children, and the state. Rather than treating parental involvement as the default and preferred safeguard for minors, the statutory framework increasingly treats parental participation as optional, unnecessary, or, in some cases, potentially adverse to the interests identified by the state. For many families, faith communities, and parents of deeply held moral or religious convictions, this shift raises significant concerns regarding the erosion of parental authority and the diminishing role of the family in guiding children through consequential medical and moral decisions.

The following provisions illustrate the scope and operation of these service-based exceptions to parental consent requirements.

A. Emergency Care

Statutory Authority: § 24-10-2

Summary. New Mexico law provides a limited exception to traditional parental consent requirements in cases involving emergency medical care for minors. A person standing in loco parentis to a minor may authorize emergency hospitalization, medical attention, or surgery when the minor requires immediate care and the child's parents cannot be located after reasonable efforts have been made under the circumstances to obtain parental consent.

The statute defines an "emergency" as an unexpected occurrence of injury or illness arising from circumstances such as motor vehicle accidents, acts of God, or other comparable accidents and events requiring immediate medical intervention. In such situations, health care providers may proceed with necessary treatment without prior parental authorization to protect the life or health of the child.

Implications for Parental Rights. Unlike many of the broader consent provisions discussed elsewhere in this report, the emergency care exception reflects a longstanding and widely accepted principle of American law: when immediate medical intervention is necessary to preserve life or prevent serious harm, treatment should not be delayed simply because a parent cannot be reached in time to provide consent.

Historically, emergency exceptions were understood as narrow, temporary, and circumstance-driven departures from ordinary parental authority. Importantly, they were not designed to displace parents from ongoing medical decision-making or to create independent health care autonomy for minors. Rather, the statutes functioned as practical safeguards intended to ensure that children received urgently needed care during unforeseen crises when parental involvement was temporarily unavailable.

For this reason, emergency consent statutes have traditionally generated far less controversy than more modern expansions of minor consent authority involving behavioral health, reproductive services, or other non-emergency treatment decisions. Nevertheless, these provisions still illustrate an important legal principle underlying New Mexico's statutory framework: under certain circumstances identified by the state, medical providers and third parties may temporarily exercise decision-making authority in place of parents when the state determines immediate intervention is necessary for the child's welfare.

The limited and narrowly tailored nature of emergency care statutes also highlights the contrast between traditional exceptions to parental consent and the far broader categories of independent minor decision-making authority that have developed in more recent years.

B. Mental and Behavioral Health and Substance Abuse Services

Statutory Authority: §§ 32A-6A-14, 32A-6A-15, 32A-6A-16, 32A-6A-20, 32A-6A-21, and 32A-6A-22

Summary. New Mexico law grants minors some of the broadest independent consent authority in the area of mental, behavioral, and substance abuse treatment. Through a series of interrelated statutory provisions, the Legislature has authorized children – particularly minors 14 years and older – to independently initiate, participate in, and in certain circumstances control significant aspects of their mental health treatment without parental consent or involvement.

The Children's Code allows a child under the age of 14 to independently initiate and consent to an initial mental health assessment with a clinician.[18] The clinician may interview the child and determine what actions or services are necessary to provide appropriate mental health or habilitation services. In addition, a child under 14 may independently consent to medically necessary early intervention services consisting of verbal therapy for up to two weeks.[19]

For minors 14 years and older, the Children's Code establishes a presumption that the child possesses the capacity to consent to mental and behavioral health treatment without the consent of the child's legal custodian.[20] These minors may independently consent to a broad range of services, including:

- individual psychotherapy;
- group psychotherapy;
- guidance counseling;
- case management;
- behavioral therapy;
- family therapy;
- counseling;
- substance abuse treatment; and
- other forms of verbal treatment that do not include aversive interventions.[21]

State law further authorizes minors 14 years and older to consent to the administration of psychotropic medications, although the treating clinician must notify the child's legal custodian.[22] In addition, the statute grants minors explicit authority to control disclosure of their mental health records and treatment information.[23] Minors 14 years and older, however, are not granted the ability to consent to the provision of special education and related services as established in federal law.[24]

[18] Section 32A-6A-14 (B) NMSA 1978.
[19] Section 32A-6A-14 (B) NMSA 1978.
[20] Section 32A-6A-15 (A) NMSA 1978.
[21] Section 32A-6A-15 (A) NMSA 1978.
[22] Section 32A-6A-15 (B) NMSA 1978.
[23] Section 32A-6A-15 (C) NMSA 1978.
[24] Section 32A-6A-15 (A) NMSA 1978.

State law further expands the role of minors in behavioral health decision-making by providing protections even where a child 14 years or older is determined to lack capacity to consent. Under this provision, such minors may not be placed into a residential treatment or habilitation program without their consent.[25] The statute also grants minors the ability to object to:

- a custodian's mental health or habilitation decisions;
- the custodian's assumption of authority over treatment decisions; or
- determinations that the child lacks capacity to consent.[26]

Additional provisions contained in §§ 32A-6A-20 through 32A-6A-22 establish procedures governing voluntary and involuntary placement of minors in residential treatment facilities, with different standards applying depending upon whether the child is under 14 years or 14 years and older.

Implications for Parental Rights. New Mexico's behavioral health consent statutes represent one of the clearest examples of the Legislature shifting significant decision-making authority away from parents and toward minors and medical professionals. Unlike narrow emergency exceptions or traditional emancipation doctrines, these provisions apply broadly to ordinary mental health, counseling, and substance abuse services and permit minors to independently engage in ongoing therapeutic relationships without parental approval.

The scope of these statutes is particularly significant because mental and behavioral health treatment often involves deeply personal, moral, developmental, and family-related issues. Counseling and therapy sessions may address matters involving sexuality, gender identity, substance abuse, family conflict, emotional trauma, religious beliefs, and other sensitive subjects central to a child's development and well-being. Yet under current law, parents may be excluded from participating in or even knowing about substantial portions of this treatment.

The statutes also create a legal framework in which minors may exercise substantial control over confidentiality and disclosure of treatment information. In practical effect, once a child independently consents to behavioral health services, parents may face substantial barriers to obtaining records, monitoring treatment plans, or participating meaningfully in therapeutic decisions involving their own child.

Particularly concerning to many parents and faith communities is the interaction between these behavioral health consent laws and New Mexico's broader policy direction regarding gender identity and sexuality. Because gender dysphoria is classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) as a diagnosable condition, these statutes may provide pathways through which minors independently access counseling, behavioral interventions, and related services connected to gender identity without parental involvement. While the precise legal limits of such authority remain uncertain, the combined effect of New Mexico's behavioral health consent statutes and broader gender-affirming care policies has generated substantial confusion and concern among parents regarding the extent to which schools, clinicians, and public institutions may facilitate such services outside the family's knowledge.

More broadly, these provisions reflect an evolving policy assumption that minors possess sufficient maturity to independently navigate complex mental health and substance abuse issues without consistent parental oversight. For many families, however, this framework fundamentally

[25] Section 32A-6A-16 (A) NMSA 1978.
[26] Section 32A-6A-16 NMSA 1978.

conflicts with the longstanding understanding that parents – not the state, schools, or health care providers – bear the primary responsibility for guiding children through periods of emotional, psychological, moral, and spiritual vulnerability.

C. Blood Donation

Statutory Authority: § 24-10-6

Summary. New Mexico law permits a minor who is at least 17 years old to donate blood to a licensed, accredited, or approved blood bank, storage facility, or hospital without obtaining parental consent.[27] The statute further provides that the minor may not receive compensation for the donation.

Implications for Parental Rights. The blood donation statute represents a relatively narrow exception to the general requirement of parental consent for medical procedures involving minors. Unlike broader statutes authorizing independent consent to behavioral health services, reproductive care, or ongoing medical treatment, this provision applies to a specific and limited medical activity involving older minors nearing the age of majority.

Historically, laws of this nature have generally been viewed as low-risk and administrative in character, reflecting the Legislature's determination that older adolescents possess sufficient maturity to voluntarily participate in medically supervised blood donation programs. Nevertheless, the statute still reflects the broader legal principle underlying many of New Mexico's minor consent laws: that the Legislature may identify categories of healthcare-related activities for which parental involvement is deemed unnecessary despite the individual remaining legally under the age of 18.

Although the practical implications for parental rights may be less substantial than in other areas addressed in this report, the provision nevertheless contributes to the growing patchwork of statutory exceptions through which minors may independently authorize healthcare-related procedures without parental knowledge or approval.

D. Sexually Transmitted Infections (STIs)

Statutory Authority: § 24-1-9, 24-1-9.3

Summary. New Mexico law provides that any person, regardless of age, possesses the legal capacity to consent to examination, preventive care, and treatment for sexually transmitted infections ("STIs") by a licensed health care provider. Parental consent is not required for a minor to seek testing, diagnosis, prevention services, or treatment relating to sexually transmitted infections.[28]

State law further require that, if a person tests positive for an STI, the health care provider must refer the individual for counseling regarding:

- the meaning and implications of the test results;
- the possible need for additional testing;
- the availability of health care services, including mental health services;
- available social and support services; and

[27] Section 24-10-6 NMSA 1978.
[28] Section 24-1-9 NMSA 1978.

- the benefits of counseling the person who may have transmitted the infection or other persons potentially exposed to the disease.[29]

Implications for Parental Rights. The STI consent statutes represent one of the broadest departures from traditional parental consent principles in New Mexico law. Unlike statutes tied to age thresholds, emancipation, or specific living circumstances, these provisions authorize independent medical consent for minors of any age. As a result, even very young minors may independently seek examination, preventive services, testing, and treatment relating to STIs without parental knowledge or involvement.

Historically, laws permitting confidential treatment for sexually transmitted diseases were justified primarily on public health grounds. Legislatures reasoned that minors might avoid testing or treatment if parental notification were required, thereby increasing the spread of communicable disease and undermining public health objectives. Over time, however, these provisions have evolved beyond narrow disease-control measures and now encompass broader categories of counseling, behavioral health referrals, and support services associated with sexual activity and related health care needs.

For many parents and faith communities, these statutes raise substantial concerns because they effectively remove parents from matters involving a child's sexual health, behavior, emotional well-being, and related moral decision-making. A parent may remain entirely unaware that a child has engaged in sexual activity, sought STI testing, received treatment, or participated in counseling and support services connected to those circumstances.

The confidentiality implications of these statutes are particularly significant when combined with federal privacy protections and related state confidentiality laws discussed later in this report. In many cases, once a minor independently consents to STI-related care, parents may have limited ability to access records or receive information concerning the diagnosis, treatment, counseling, or follow-up care provided to their child.

More broadly, the STI consent framework reflects the Legislature's increasing willingness to prioritize minor privacy and independent health care access over parental involvement in sensitive medical and moral matters. For many families, this represents a substantial shift away from the traditional understanding that parents should remain the primary source of guidance, accountability, and support for children navigating issues relating to sexuality, health, and personal responsibility.

E. HIV Testing

Statutory Authority: § 24-2B-3 and 24-2B-4

Summary. New Mexico law authorizes minors to independently consent to testing for the human immunodeficiency virus ("HIV") without parental involvement.[30] If the test result is positive, the statute requires that the minor be provided with or referred for individual counseling concerning:

- the meaning and implications of the test result;
- the possible need for additional testing;
- the availability of appropriate health care services, including mental health services;

[29] Section 24-1-9.3 NMSA 1978.
[30] Section 24-2B-3 NMSA 1978.

- available social and support services; and
- the benefits of locating and counseling the individual who may have transmitted the infection or others who may have been exposed.[31]

Implications for Parental Rights. Like the statutes governing sexually transmitted infections generally, New Mexico's HIV testing provisions reflect a public policy decision to prioritize confidential access to testing and treatment over parental involvement. Legislatures historically justified such laws on the grounds that concerns regarding privacy or parental notification might discourage minors from seeking testing or treatment, thereby undermining broader public health objectives.

At the same time, these statutes represent a significant limitation on the traditional role of parents in overseeing and guiding their children's health care decisions. HIV testing and related counseling may involve deeply sensitive matters relating to sexual behavior, substance abuse, mental health, and personal relationships. Yet under current law, a minor may independently initiate testing and receive counseling and referrals without parental knowledge or participation.

The counseling provisions accompanying positive HIV test results further illustrate the increasingly expansive nature of modern minor consent statutes. The law contemplates not merely medical testing itself, but also referrals to mental health services, social services, and support systems that may operate independently of the family unit. In practice, parents may remain unaware that their child has undergone testing, received a diagnosis, or participated in related counseling and support services.

When combined with broader federal and state confidentiality protections discussed later in this report, these statutes may significantly limit parental access to medical records and treatment information associated with HIV-related care. As a result, parents may be excluded from some of the most serious and consequential medical and emotional circumstances affecting their child despite continuing to bear primary responsibility for the child's welfare and support.

More broadly, the HIV testing statutes reflect the Legislature's continuing movement toward a health care framework in which minors are increasingly treated as autonomous decision-makers in areas involving sexuality, behavioral health, and personal medical privacy. For many families and faith communities, this shift raises substantial concerns regarding the erosion of parental authority and the diminishing role of parents in providing moral guidance, emotional support, and informed oversight during critical moments in a child's development.

F. Contraceptives and Family Planning

Statutory Authority:§§ 24-8-2 and 24-8-5

Summary. New Mexico law provides that any person, regardless of age, may consent to family planning services without parental involvement.[32] "Family planning services" is broadly defined to include:

- contraceptive procedures and services;
- diagnosis and treatment relating to contraception;
- contraceptive supplies and follow-up care; and

[31] Section 24-2B-4 NMSA 1978.
[32] Section 24-8-5 NMSA 1978.

- related social, educational, informational, and support services.[33]

The statute does not establish a minimum age requirement for consent and does not require parental notification or approval before a minor may obtain these services.

Implications for Parental Rights. The family planning statute represents one of the broadest assertions of independent health care autonomy granted to minors under New Mexico law. Unlike provisions tied to age thresholds, emancipation status, or emergency circumstances, this statute authorizes individuals of any age to independently access contraception-related services and related counseling without parental knowledge or involvement.

Historically, statutes authorizing confidential access to contraceptive services were often justified on public health and pregnancy-prevention grounds. Proponents argued that minors might avoid seeking medical advice or contraception if parental involvement were required, thereby increasing rates of unintended pregnancy and associated health and social consequences. Over time, however, the scope of "family planning services" has expanded well beyond the mere provision of contraceptive devices and now includes broader educational, informational, counseling, and social services relating to sexuality and reproductive health.

For many parents and faith communities, these provisions raise significant concerns because they remove parents from decisions involving a child's sexual behavior, moral development, and reproductive health. Parents may remain entirely unaware that their child has sought contraception, received counseling regarding sexual activity, or participated in related educational or support services. In practical effect, the statute permits health care providers, counselors, and publicly funded clinics to address deeply personal and morally significant issues outside the knowledge and guidance of the family.

The interaction between this statute and broader confidentiality protections further magnifies these concerns. Once a minor independently consents to family planning services, federal and state privacy laws may significantly restrict parental access to records, billing information, treatment plans, and related communications. As discussed later in this report, the combined effect of consent and confidentiality laws may effectively exclude parents from substantial areas of their child's reproductive healthcare.

More broadly, the contraceptive and family planning statutes reflect the Legislature's continuing movement toward a framework in which minors are increasingly treated as autonomous decision-makers in matters involving sexuality and reproductive health. For many New Mexico families, this represents a substantial departure from the longstanding principle that parents bear the primary responsibility for guiding their children's moral, emotional, and physical development during adolescence.

G. Pregnancy Care

Statutory Authority

- §§ 24-1-13 and 24-1-13.1

Summary. New Mexico law grants minors broad authority to independently consent to pregnancy-related health care services without parental involvement. Any person, regardless of age,

[33] Section 24-8-2 (B) NMSA 1978.

possesses the legal capacity to consent to pregnancy diagnosis care.[34] In addition, a female minor may independently consent to prenatal care, delivery-related medical services, and postnatal care without parental consent or notification.[35]

These statutes authorize health care providers to furnish pregnancy-related medical services directly to the minor, and the validity of the minor's consent is not dependent upon the participation or approval of a parent or legal guardian.

Implications for Parental Rights. The pregnancy care statutes represent one of the clearest examples of New Mexico law authorizing minors to independently make highly consequential medical decisions without parental involvement. Unlike limited emergency exceptions or narrowly tailored procedural statutes, these provisions encompass an extensive continuum of medical care involving pregnancy diagnosis, prenatal treatment, childbirth, and postnatal services.

Historically, legislatures often justified such laws on the grounds that pregnant minors required timely access to medical care to protect the health of both the mother and child. Supporters argued that fear of parental notification might discourage some minors from seeking necessary medical treatment during pregnancy, thereby increasing health risks and adverse outcomes. As a result, many states created exceptions permitting pregnant minors to independently obtain pregnancy-related healthcare.

At the same time, these statutes significantly limit the traditional role of parents in guiding and supporting their children through major medical, emotional, moral, and life-altering circumstances. Pregnancy and childbirth carry profound physical, psychological, familial, and spiritual implications, yet under current law a minor may independently obtain diagnosis, prenatal care, and related medical services without parental knowledge or participation.

For many parents and faith communities, these provisions raise substantial concerns because they effectively separate deeply consequential reproductive decisions from family involvement and parental guidance. Parents may remain unaware that their child is pregnant, receiving prenatal care, or making decisions regarding pregnancy-related treatment and services until long after those decisions have occurred. In practical effect, health care providers and public institutions may become the primary sources of counseling, information, and support during one of the most significant events in a minor's life.

The interaction between these statutes and broader confidentiality protections further amplifies these concerns. Once a minor independently consents to pregnancy-related care, state and federal privacy laws may significantly restrict parental access to medical records, communications, billing information, and treatment details. As discussed later in this report, the combined effect of consent and confidentiality laws often operates to exclude parents from meaningful participation in some of the most consequential health care decisions affecting their children.

More broadly, the pregnancy care statutes reflect the Legislature's continuing movement toward recognizing independent reproductive decision-making authority in minors regardless of age. For many New Mexico families, this shift represents a substantial departure from the longstanding legal and cultural understanding that parents should remain central participants in guiding and supporting their children through major medical and moral decisions during adolescence.

[34] Section 24-1-13 NMSA 1978.
[35] Section 24-1-13.1 NMSA 1978.

H. Withholding Life-Sustaining Treatment

Statutory Authority: § 24-7A-6.1

Summary. New Mexico law authorizes certain unemancipated minors to participate directly in end-of-life medical decision-making. An unemancipated minor who possesses the capacity to understand the nature of the minor's medical condition, the risks and benefits of treatment, and the contemplated decision to withhold or withdraw life-sustaining treatment may consent to the withholding or withdrawal of life-sustaining medical treatment.[36]

For purposes of making this determination, the statute requires the minor's mental and emotional capacity be evaluated by two qualified health care professionals.[37] One evaluator must be the unemancipated minor's primary care practitioner, while the second must be a health care practitioner who ordinarily works with minors of the child's age group in the course of professional practice. If the minor's capacity is potentially impaired due to mental illness or developmental disability, one of the evaluating professionals must possess training and expertise relevant to assessing functional impairment associated with those conditions.

The statute therefore permits qualifying minors to participate in decisions involving the continuation or cessation of medical interventions intended to sustain life, provided the minor is determined to have sufficient decisional capacity under the standards set forth in law.

Implications for Parents Rights. Among New Mexico's minor consent statutes, the authority to participate in decisions involving the withholding or withdrawal of life-sustaining treatment represents one of the most profound and consequential delegations of decision-making authority to minors. Unlike statutes involving limited outpatient services or discrete categories of care, this provision implicates end-of-life decisions carrying extraordinary emotional, moral, spiritual, and ethical significance.

Historically, decisions involving life-sustaining treatment were understood to fall squarely within the authority and responsibility of parents acting in consultation with physicians and, in many cases, spiritual advisors and family members. Parents traditionally served as the primary advocates and decision-makers for their children during periods of severe illness or medical crisis, reflecting the longstanding legal presumption that parents are best positioned to safeguard the welfare and interests of their children in the most difficult circumstances imaginable.

Section 24-7A-6.1 NMSA 1978 alters that traditional framework by recognizing that certain unemancipated minors may independently consent to decisions involving the withdrawal or withholding of life-sustaining care. Although the statute requires the minor possess sufficient capacity to understand the nature and consequences of the decision, the law nevertheless reflects the Legislature's willingness to recognize substantial medical autonomy in minors even in matters involving life-and-death consequences.

For many families and faith communities, the statute raises particularly serious concerns because decisions surrounding life-sustaining treatment often involve deeply held religious convictions, moral beliefs, and family values concerning human dignity, suffering, and the sanctity of life. The prospect that such decisions may occur with diminished parental authority or in conflict with

[36] Section 24-7A-6.1 (C) NMSA 1978.
[37] Section 24-7A-6.1 (D) NMSA 1978.

parental judgment represents a significant departure from the traditional understanding of the family's role during medical crises.

The provision also illustrates the broader trajectory of New Mexico's statutory framework governing minor consent. What began historically as narrow exceptions for emergency or limited public health purposes has gradually expanded into areas involving some of the most consequential medical and ethical decisions imaginable. In doing so, the law increasingly recognizes minors as independent medical decision-makers in circumstances that were once viewed as inseparable from parental guidance, family involvement, and moral responsibility.

II. Reproductive and Gender-Affirming Health Care Freedom Act

In 2023, the New Mexico Legislature enacted House Bill 7, known as the Reproductive and Gender-Affirming Health Care Freedom Act ("the Act"). The legislation represented a significant expansion of state policy favoring broad access to reproductive and gender-related health care services and reflected an increasingly aggressive shift away from parental involvement and local control in matters involving children, families, and health care decision-making.

The Act broadly prohibits public bodies – and any entity or individual acting on behalf of a public body – from:

1. Denying, restricting, or interfering with a person's ability to access or provide reproductive health care or gender-affirming health care within the medical standard of care;[38]
2. Prosecuting, punishing, or otherwise depriving a person of the ability to act or refrain from acting during pregnancy based upon the actual, perceived, or potential effect on the pregnancy;[39] and
3. Imposing or maintaining any law, ordinance, policy, or regulation that conflicts with the provisions of the Act.[40]

Importantly, the Act defines "public body" expansively to include state and local governments, school districts, public colleges and universities, political subdivisions, agencies, commissions, and entities receiving public funding.[41] As a result, the law reaches deeply into public institutions that regularly interact with children and families, including public schools, school-based health centers, counselors, and publicly funded health care providers.

The Act further defines "gender-affirming healthcare" broadly to include "psychological, behavioral, surgical, pharmaceutical and medical care, services, and supplies provided to support a person's gender identity."[42] Likewise, "reproductive healthcare" is defined broadly to include "psychological, behavioral, pharmaceutical, surgical, and medical services relating to pregnancy, contraception, abortion, fertility, sexually transmitted infections, and related matters."[43]

Although the Act does not expressly state that minors may independently consent to all forms of gender-affirming or reproductive healthcare, the breadth and structure of the law have created

[38] Section 24-34-3 (B) NMSA 1978.
[39] Section 24-34-3 (C) NMSA 1978.
[40] Section 24-34-3 (D) NMSA 1978.
[41] Section 24-34-2 (B) NMSA 1978.
[42] Section 24-34-2 (A) NMSA 1978.
[43] Section 24-34-2 (C) NMSA 1978.

substantial uncertainty regarding its interaction with existing parental consent statutes. Existing New Mexico law already authorizes minors to independently consent to a growing range of behavioral health, reproductive health, and medical services. Because the Act broadly prohibits governmental entities from "restricting" or "interfering" with access to gender-affirming healthcare, many parents and community leaders reasonably fear that public institutions may interpret the law as discouraging – or even prohibiting – parental involvement when minors seek such services.

This concern is heightened by the fact that gender dysphoria is recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) as a diagnosable mental health condition. Existing New Mexico law already permits minors 14 years or older to independently consent to a range of behavioral and mental health services without parental involvement. At the same time, professional organizations advocating for gender-affirming care often describe treatment as including psychological counseling, social transition, puberty blockers, hormone therapy, and, in limited circumstances, surgical interventions. While New Mexico statutes do not clearly authorize minors to independently consent to every category of these interventions, neither do existing laws clearly prohibit such outcomes when combined with the broad language and policy direction reflected in the Act.

During House floor debate, Republican legislators proposed amendments intended to clarify that the Act would not override parental authority regarding minors. One amendment would have limited the protections of the Act to adults 18 years of age or older. Another would have expressly required parental consent before a minor could obtain abortion services or gender-affirming healthcare. Neither amendment was adopted. The Legislature's rejection of these proposals has contributed to ongoing concern among parents, faith leaders, educators, and local officials regarding the intended scope of the Act and the extent to which parental rights remain protected under New Mexico law.

Compounding these concerns is the increasingly prominent role that schools, school counselors, behavioral health providers, and school-based health clinics play in addressing issues relating to gender identity and sexuality. Many parents fear that the current legal framework creates pressure on public institutions to affirm and facilitate a child's gender-related decisions while minimizing or bypassing parental involvement altogether. Even where the law may not explicitly grant minors independent authority to consent to all forms of treatment, the practical effect of the Act may be to encourage public entities to err on the side of secrecy, non-disclosure, or exclusion of parents in order to avoid allegations that they are "interfering" with access to care.

The result is a growing perception among many New Mexico families that the State increasingly views parents not as the primary guides and protectors of their children, but as potential obstacles to state-approved health care and social policy objectives. Whether intended or not, the cumulative effect of these policies has been to undermine parental confidence in public institutions and to create substantial confusion regarding the respective roles of parents, schools, health care providers, and minors in making deeply consequential medical and moral decisions.

III. Confidentiality, Disclosure, and Parental Access to Medical Information

The expansion of minor consent authority carries consequences extending far beyond the initial medical decision itself. In practice, the ability of a minor to independently consent to health care frequently operates in tandem with federal and state confidentiality laws that limit or entirely prohibit parental access to information concerning that care. As a result, the question is no longer simply whether a child may obtain medical treatment without parental consent, but whether parents may even be informed that treatment occurred at all.

A complex network of federal and state privacy laws governs the confidentiality and disclosure of medical, behavioral health, educational, and insurance information relating to minors. These laws include the federal Health Insurance Portability and Accountability Act (HIPAA), federal substance abuse confidentiality protections under 42 C.F.R. Part 2, the Family Educational Rights and Privacy Act (FERPA), provisions governing insurance billing and explanation-of-benefits disclosures, and electronic medical record access requirements established under the 21st Century Cures Act. In many circumstances, these laws interact with New Mexico's minor consent statutes in ways that significantly limit parental access to information concerning their own child's healthcare. *See* Appendices B, C, D, E, F, and G.

Historically, parents have been presumed to possess both the right and the responsibility to oversee the medical care of their children. That responsibility necessarily depended upon access to information regarding a child's diagnosis, treatment, medications, counseling, and overall health condition. Increasingly, however, modern confidentiality frameworks treat minors – particularly in areas involving behavioral health, sexuality, reproductive services, substance abuse treatment, and gender-related care – as independent holders of privacy rights whose interests may be protected from parental knowledge or involvement.

In practical effect, consent and confidentiality are inseparable. Once the law authorizes a minor to independently consent to care, the law often correspondingly limits the parent's ability to access records, receive disclosures, monitor treatment, review communications, or participate in ongoing medical decision-making. This creates a legal framework in which parents may remain financially, morally, and legally responsible for the well-being of their children while simultaneously being denied meaningful access to information necessary to fulfill those responsibilities.

These confidentiality protections are often justified as necessary to encourage vulnerable minors to seek medical or behavioral health services without fear of disclosure. However, for many parents, faith communities, and family advocates, the cumulative effect of these laws represents a profound shift in the relationship between families, medical providers, schools, and the state. Rather than reinforcing the family as the primary source of protection, guidance, and accountability for children, the modern confidentiality framework increasingly positions parents as secondary participants – or, in some cases, excluded parties – in some of the most consequential decisions affecting their children's physical, emotional, and moral development.

The following sections outline the principal state confidentiality laws implicated by New Mexico's minor consent statutes and examine how those laws operate to restrict parental access to medical and educational information concerning their children.

A. Mental Health and Substance Abuse Information – Access and Disclosure

Statutory Authority: § 32A-6A-24

Summary. New Mexico law establishes a detailed confidentiality framework governing mental health, developmental disability, and substance abuse treatment records involving minors. Under § 32A-6A-24, confidential information relating to a child's treatment generally may not be disclosed without authorization from the child or other legally authorized individual.

The statute creates different disclosure rules depending upon the age and capacity of the minor.

For children under 14 years old, the child's legal custodian is generally authorized to consent to disclosure of confidential information on behalf of the child. A court-appointed guardian ad litem may also receive information without consent.

For minors 14 years and older who possess the capacity to consent to disclosure, the statute grants the minor the right to control disclosure of mental health and habilitation records. In these circumstances, the minor may authorize or refuse disclosure of confidential treatment information. A legal custodian retains broader rights to request and receive information only when evidence establishes that the child lacks capacity to provide valid consent and no court-appointed treatment guardian exists.

The statute also establishes several exceptions permitting disclosure without authorization in limited circumstances, including:

- disclosures necessary for treatment purposes between clinicians;
- disclosures necessary to prevent a clear and substantial risk of imminent serious physical injury or death;
- limited disclosures to legal custodians when a clinician determines disclosure would not substantially harm the child;
- disclosures necessary for continuity of care to a primary caregiver;
- limited disclosures to insurers for payment purposes;
- disclosures ordered by a court for good cause shown; and
- certain research-related disclosures permitted under state and federal law.

Even where disclosure to parents or legal custodians is permitted, the statute generally limits the information shared to summaries of assessments, treatment plans, progress, discharge planning, and other information deemed essential by the treating clinician.

The law further grants minors rights to access and review their own confidential records, submit clarifying statements, and seek court orders regarding access disputes. At the same time, a physician or mental health professional may deny the child access to records if disclosure is determined not to be in the child's best interests.

Finally, the statute expressly provides that nothing within the Children's Mental Health and Developmental Disabilities Act limits broader confidentiality protections afforded under federal law, including federal health care privacy statutes and regulations.

Implications for Parental Rights. Although this section of law does not entirely eliminate parental access to a child's behavioral health information, the statute substantially restructures

the traditional relationship between parents, children, and health care providers regarding confidentiality and disclosure.

Historically, parents were generally presumed to possess broad authority to oversee and participate in decisions involving their child's mental health treatment. Meaningful parental involvement depended upon access to diagnoses, counseling information, treatment recommendations, behavioral assessments, medication information, and related medical records. Under New Mexico's current statutory framework, however, minors 14 years and older who are deemed capable of consenting increasingly control disclosure of their own mental health and substance abuse treatment information.

In practical effect, parents may receive only limited summaries or disclosures determined appropriate by the treating clinician rather than full access to treatment records or counseling communications. Providers are granted substantial discretion to determine what information may be shared, whether disclosure could substantially harm the child, and whether parental access is appropriate under the circumstances.

These limitations are particularly significant because behavioral health treatment frequently involves highly sensitive issues relating to sexuality, gender identity, substance abuse, family conflict, emotional trauma, religious beliefs, and personal development. Parents may therefore have limited ability to evaluate the nature of counseling being provided, recommendations being made to their child, or the long-term implications of ongoing behavioral health treatment.

The statute also reflects a broader policy shift toward recognizing minors as independent participants in health care privacy and disclosure decisions. Once a minor is authorized to independently consent to treatment, confidentiality laws frequently operate to restrict parental access to the very information necessary for meaningful parental oversight. As a result, health care providers, counselors, schools, and public institutions may increasingly function as primary decision-makers regarding what information parents may receive concerning their child's emotional and psychological well-being.

For many families and faith communities, this framework represents a substantial departure from the longstanding understanding that parents should remain the principal guides, protectors, and decision-makers in matters affecting their children's mental, emotional, and moral development.

B. STI & HIV Test Results – Disclosure

Statutory Authority: §§ 24-1-9.4 and 24-2B-6

Summary. Under state law, information concerning STI examinations, diagnoses, treatment, and HIV test results is generally treated as confidential and may only be disclosed under limited circumstances authorized by law.[44]

Because New Mexico law separately grants minors the authority to independently consent to STI-related care and HIV testing regardless of age,[45] these confidentiality provisions operate to protect the privacy of minors who seek such services without parental involvement.

[44] Section 24-1-9.5 (A) and 24-2B-6 (A) NMSA 1978.
[45] Section 24-1-9 and 24-2B-2 NMSA 1978.

The statutes generally restrict disclosure of STI and HIV-related information except for limited purposes authorized by law, such as:

- disclosures necessary for medical treatment;
- public health reporting requirements;
- disclosures authorized by the patient;
- certain court-authorized disclosures; or
- other disclosures specifically permitted under state or federal law.[46]

In practice, these confidentiality protections apply not only to test results themselves, but also to related records concerning examinations, diagnoses, counseling, referrals, and treatment associated with STI and HIV-related care.

Implications for Parental Rights. The confidentiality provisions governing STI- and HIV-related information substantially reinforce the independent consent authority granted elsewhere in New Mexico law. While statutes authorizing minors to independently seek testing and treatment already limit parental involvement, the accompanying disclosure restrictions often prevent parents from obtaining information concerning whether testing occurred, what diagnoses were made, or what treatment and counseling services were provided.

As a practical matter, a parent may remain entirely unaware that a child has sought STI or HIV testing, treatment, counseling, or related health care services. Once a minor independently consents to such care, confidentiality laws may significantly restrict disclosure of medical records, provider communications, treatment information, laboratory results, and related counseling services.

These provisions are particularly significant because STI- and HIV-related treatment frequently involves broader issues relating to sexual activity, substance abuse, mental health, emotional well-being, and personal relationships. In many cases, health care providers may become the primary source of guidance, counseling, and support regarding highly sensitive matters that historically would have involved parental participation and oversight.

The statutes also reflect the broader policy rationale underlying many modern minor confidentiality laws: that minors may avoid testing or treatment if parental notification is required. While proponents argue that confidentiality encourages access to care and promotes public health objectives, critics contend that these laws substantially undermine the ability of parents to fulfill their traditional role in guiding, protecting, and supporting their children through significant medical, emotional, and moral issues.

When combined with federal health care privacy protections discussed later in this report, New Mexico's STI and HIV confidentiality statutes contribute to a legal framework in which minors increasingly exercise adult-like control over sensitive medical information despite remaining legally under the care and responsibility of their parents. For many families and faith communities, this represents a significant erosion of the traditional presumption that parents should remain informed participants in major health care decisions affecting their children.

[46] Section 24-1-9.4 and Section 24-2B-6 NMSA 1978.

C. Psychotropic Drugs – Disclosure

Statutory Authority: § 32A-6A-15

Summary. New Mexico law permits minors 14 years and older to consent to the administration of psychotropic medications as part of behavioral health treatment without obtaining parental consent.[47] State law presumes a child 14 years or older possesses the capacity to consent to mental health treatment, including the administration of psychotropic medications.

Although the statute authorizes the minor to consent independently to such treatment, it also requires that the treating clinician notify the child's legal custodian regarding the administration of psychotropic medication.[48] The law therefore creates a limited disclosure requirement even where parental consent itself is not required.

Implications for Parental Rights. *This* reflects a significant shift in the balance between parental authority and minor autonomy in the area of behavioral health treatment. Historically, decisions involving psychotropic medications – many of which can substantially affect mood, cognition, behavior, emotional regulation, and neurological development – were generally understood to require meaningful parental involvement and oversight.

Under current New Mexico law, however, a minor 14 years or older may independently consent to the administration of psychotropic drugs without parental approval. Parents retain only a limited right to notification after treatment decisions have already been made between the child and the treating provider.

This distinction between notification and consent is substantial. While parents may be informed that psychotropic medications are being administered, the statute does not provide parents with authority to approve, deny, or direct treatment decisions once the qualifying minor has independently consented. In practical effect, health care providers and minors may jointly make significant psychiatric treatment decisions while parents are relegated to a largely informational role.

The practical implications of this framework are particularly significant because psychotropic medications are often prescribed in connection with serious behavioral health diagnoses involving depression, anxiety, trauma, attention disorders, substance abuse, mood disorders, and issues relating to gender identity or emotional distress. These medications may involve substantial side effects, long-term treatment plans, and complex medical and psychological considerations requiring ongoing monitoring and support.

For many families and faith communities, the statute raises concerns that parents may be denied meaningful participation in major psychiatric treatment decisions affecting their children despite continuing to bear responsibility for the child's welfare, emotional stability, and long-term development. Parents may disagree with a diagnosis, treatment philosophy, counseling approach, or medication plan, yet possess limited legal authority to intervene once a qualifying minor independently consents to treatment.

More broadly, Section 32A-6A-15 illustrates the increasingly common legislative approach of separating parental notification from parental authority. Although the statute preserves a limited

[47] Section 32A-6A-15 NMSA 1978.
[48] Section 32A-6A-15 NMSA 1978.

disclosure requirement, the underlying decision-making power rests largely with the minor and health care provider rather than the family unit. For many New Mexico families, this represents a significant departure from the longstanding principle that parents should remain the primary decision-makers in matters involving a child's medical and psychological care.

D. Child Abuse Reporting

Statutory Authority: §§ 32A-4-2 and 32A-4-3

Summary. New Mexico law imposes broad mandatory reporting obligations relating to suspected child abuse and neglect. Any person who knows or has a reasonable suspicion that a child is being abused or neglected must report that information to the New Mexico Children, Youth and Families Department ("CYFD"), law enforcement, or other appropriate authorities.[49]

The reporting obligation applies broadly and includes health care providers, counselors, therapists, school personnel, social workers, and other professionals who may obtain information through the course of treatment or confidential communications.[50] Importantly, the statutes provide that mandatory abuse reporting obligations apply notwithstanding other confidentiality or privacy protections that might otherwise restrict disclosure of information.

As a result, confidential treatment information obtained during counseling, behavioral health treatment, medical care, substance abuse treatment, or other protected health care services may be disclosed when necessary to comply with mandatory child abuse reporting requirements under state law.

Implications for Parental Rights. Unlike many of the confidentiality provisions discussed elsewhere in this report, New Mexico's mandatory child abuse reporting statutes are not designed primarily to expand minor autonomy or restrict parental access to information. Instead, these provisions reflect the longstanding and widely accepted principle that the state possesses a compelling interest in protecting children from abuse, neglect, and serious harm.

Historically, mandatory reporting laws developed to ensure that health care providers, educators, counselors, and other professionals could not withhold information concerning suspected abuse based on professional confidentiality obligations. In this respect, the statutes serve a fundamentally different purpose than laws granting minors independent authority to consent to confidential health care services.

At the same time, these provisions illustrate the increasingly complex interaction between confidentiality laws, mandatory reporting obligations, and parental rights. Although health care providers and counselors may be prohibited from disclosing certain information directly to parents under minor consent and confidentiality statutes, those same providers may still be legally obligated to disclose information to state authorities if abuse or neglect is suspected.

In practical effect, this framework may create circumstances in which health care providers, counselors, school officials, or behavioral health professionals communicate sensitive information to government agencies while parents themselves remain excluded from portions of the underlying treatment information or counseling records. For many families, this dynamic

[49] Section 32A-4-3 (A) NMSA 1978.
[50] Section 32A-4-3 (A) NMSA 1978.

contributes to broader concerns that parents are increasingly displaced from their traditional role as the primary authority over their child's care, discipline, emotional development, and welfare.

The mandatory reporting statutes also highlight the significant discretion often exercised by health care providers, counselors, educators, and state agencies in determining when confidential information should be disclosed to the government. Because reporting obligations are triggered not only by actual knowledge but also by "reasonable suspicion," providers may disclose sensitive family information to state authorities based upon subjective assessments formed during counseling sessions, medical treatment, or school interactions.

Nevertheless, unlike many of the statutes discussed elsewhere in this report, New Mexico's child abuse reporting laws are grounded in the state's recognized responsibility to intervene where necessary to protect children from serious harm. The broader concern for many parents and faith communities arises not from the existence of abuse reporting requirements themselves, but from the expanding legal framework in which schools, health care providers, counselors, and public institutions increasingly operate as intermediaries between children and the state while parental authority and involvement continue to diminish in other areas of law.

FEDERAL CONFIDENTIALITY LAWS

In addition to New Mexico's statutory framework governing minor consent and disclosure of medical information, a complex network of federal privacy laws further limits parental access to a child's health care records and treatment information. Although these federal laws were generally enacted to protect patient privacy, encourage access to care, and standardize medical information practices, they frequently operate in conjunction with state minor consent statutes to significantly restrict parental oversight of a child's medical, behavioral, and reproductive healthcare.

Importantly, many of these federal laws do not themselves determine when a minor may consent to treatment. Rather, they often defer to state law on questions of consent and parental authority. Once state law authorizes a minor to independently consent to particular health care services, however, federal confidentiality laws frequently recognize the minor as the controlling party for purposes of disclosure and access to records. As a result, parental rights may be substantially diminished not only because minors may independently obtain treatment, but also because parents may thereafter be denied meaningful access to information concerning that treatment.

The interaction between state consent laws and federal confidentiality protections has created a legal environment that is often highly complex, difficult for families to navigate, and inconsistently understood by health care providers, schools, insurers, and public institutions. In practice, many parents are surprised to discover that although they remain legally responsible for the support and welfare of their children, they may nevertheless be denied access to health care information involving counseling, reproductive services, substance abuse treatment, sexually transmitted infections, gender-related services, or other sensitive areas of care.

A. Health Insurance Portability and Accountability Act (HIPAA)[51]

The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes nationwide privacy protections governing protected health information maintained by health care providers, insurers, and other covered entities. In general, HIPAA recognizes parents as the personal representatives of their unemancipated minor children and therefore permits parents to access a child's medical records.

However, HIPAA contains important exceptions that substantially limit parental access where state law authorizes minors to independently consent to health care services. When a minor lawfully consents to care under state law and parental consent is not required, HIPAA may treat the minor as the individual controlling access to the related medical information. In those circumstances, health care providers may decline to disclose records or treatment information to parents without the minor's authorization.

HIPAA also grants health care providers discretion to withhold information from parents when the provider reasonably believes disclosure would not be in the child's best interests or could endanger the child. As a result, health care providers frequently exercise significant discretion in determining whether parents may access records involving behavioral health treatment, reproductive healthcare, substance abuse services, or other sensitive treatment areas.

[51] See Appendix B for more information.

B. Title X Family Planning Confidentiality Requirements[52]

Federal Title X family planning programs impose additional confidentiality protections relating to reproductive health care services provided through federally funded family planning programs. Clinics receiving Title X funding generally must provide confidential access to family planning services, including contraceptive services and related counseling.

Historically, Title X regulations and guidance have emphasized confidential access for minors seeking reproductive health care services. Although providers are encouraged to involve parents where practical, federal law generally prohibits Title X providers from requiring parental consent or parental notification as a condition of receiving services.

Because New Mexico law separately authorizes minors to consent to contraceptive and family planning services, Title X confidentiality requirements may further reinforce limitations on parental access to records, counseling information, and treatment details relating to reproductive health care provided through federally funded programs.

C. 42 C.F.R. Part 2 – Substance Abuse Treatment Records[53]

Federal regulations codified at 42 C.F.R. Part 2 establish particularly stringent confidentiality protections governing records relating to substance abuse diagnosis, treatment, and referral services provided by federally assisted substance use treatment programs.

These regulations strictly limit disclosure of substance abuse treatment information and generally prohibit disclosure without patient consent except in narrowly defined circumstances. When state law authorizes minors to independently consent to substance abuse treatment, these federal confidentiality rules may significantly restrict parental access to treatment information, counseling records, and related communications.

As a result, parents may encounter substantial obstacles when attempting to obtain information concerning a child's substance abuse treatment, even where the parent remains financially and legally responsible for the child's care and well-being.

D. Family Educational Rights and Privacy Act (FERPA)[54]

The federal Family Educational Rights and Privacy Act ("FERPA") governs access to educational records maintained by schools and educational institutions receiving federal funding. FERPA generally grants parents the right to inspect and review educational records relating to their children.

However, FERPA's application becomes increasingly complicated in the context of school-based health care services and school-based health clinics. Depending upon how records are maintained, and which entity controls them, some health care records generated in schools may be governed by FERPA rather than HIPAA. In other circumstances, records maintained by outside health care providers operating on school campuses may remain subject to HIPAA or other federal confidentiality laws.

[52] See Appendix C for more information.
[53] See Appendix D for more information.
[54] See Appendix E for more information.

As schools increasingly provide behavioral health counseling, social-emotional services, gender-related support services, and health care referrals, parents often face uncertainty regarding what information they may access and what records may be withheld under federal privacy rules. This confusion is particularly significant in light of growing concerns among parents regarding school involvement in issues relating to gender identity, mental health treatment, and reproductive healthcare.

E. Health Insurance Claims, Billing, and Explanation of Benefits Issues[55]

Even where medical records themselves remain confidential, health care billing and insurance practices often create additional complications involving parental access to information. In some circumstances, insurance claims, explanation-of-benefits forms ("EOBs"), billing statements, or payment records may inadvertently disclose information concerning confidential health care services obtained by minors.

At the same time, federal and state privacy rules increasingly encourage health care systems and insurers to limit disclosure of sensitive services through billing practices, electronic portals, and communications controls. As health care systems continue transitioning toward electronic medical records and online patient portals, disputes increasingly arise regarding whether parents may access information through shared accounts or electronic applications.

The practical result is often confusion for both families and providers regarding what information may lawfully be disclosed, what information must remain confidential, and who ultimately controls access to a minor's health care records and communications.

F. Electronic Health Information and the 21st Century Cures Act[56]

The federal 21st Century Cures Act and related federal interoperability regulations promote expanded electronic access to health care information through online portals, application programming interfaces (APIs), and electronic health record systems. These laws were designed primarily to improve patient access to health information and reduce barriers to electronic information sharing.

However, the expansion of electronic health information systems has created additional complexities regarding parental access to minor medical records. Health care providers and electronic record systems increasingly must determine how to segregate confidential minor records, limit parental portal access, and comply simultaneously with state minor consent laws, HIPAA requirements, and federal interoperability mandates.

As a result, health care providers, school-based clinics, counselors, insurers, and public institutions frequently struggle to navigate overlapping federal and state confidentiality requirements. Parents likewise may find themselves unexpectedly excluded from electronic records, online portals, appointment information, prescription records, counseling notes, or treatment communications involving their children.

[55] See Appendix F for more information.
[56] See Appendix G for more information.

G. Broader Policy Considerations

Taken together, these federal confidentiality laws substantially amplify the practical effect of New Mexico's expanding minor consent statutes. While state law increasingly authorizes minors to independently consent to behavioral health treatment, reproductive healthcare, substance abuse services, STI treatment, and other sensitive medical care, federal privacy laws often operate to shield those services from parental review and oversight.

For many families and faith communities, the combined effect of these laws represents a profound restructuring of the traditional relationship between parents, children, health care providers, schools, and the state. Parents may continue to bear primary legal, financial, moral, and emotional responsibility for raising their children while simultaneously being denied meaningful access to information concerning major health care decisions affecting their child's physical, psychological, and spiritual well-being.

At minimum, the interaction between these federal and state laws has created substantial confusion among parents, educators, health care providers, school-based clinics, insurers, and public institutions regarding the scope of parental rights and the extent to which minors may independently control health care decisions and medical information.

IMPACTS ON FAMILIES AND POLICY CONSIDERATIONS

For many New Mexico parents, grandparents, pastors, and people of faith, the issues discussed throughout this report are not abstract legal questions. They reach directly into the heart of the family and concern who will ultimately guide the moral, emotional, spiritual, and physical development of children.

For generations, families across New Mexico operated under a basic understanding: parents – not the government – were primarily responsible for raising children, directing their education, overseeing their healthcare, and teaching moral and religious values. That understanding was reflected not only in religious tradition and community values, but also in longstanding constitutional principles recognizing the family as the foundational institution of society.

Today, however, many families increasingly feel that this traditional role is being displaced.

As outlined throughout this report, New Mexico law now allows minors in many circumstances to consent to behavioral health treatment, reproductive healthcare, substance abuse counseling, STI treatment, psychotropic medications, and potentially even certain forms of gender-related care without parental consent or involvement. At the same time, confidentiality laws often prevent parents from accessing records, counseling information, diagnoses, treatment plans, or communications relating to that care.

The cumulative effect is significant. Parents may remain legally responsible for feeding, housing, supporting, educating, transporting, disciplining, and protecting their children, while simultaneously being denied meaningful involvement in some of the most serious medical, emotional, and psychological decisions affecting their child's life.

For many faith-based families, these developments raise especially serious concerns because many of the issues implicated by these laws – sexuality, gender identity, reproductive decisions, counseling philosophies, psychotropic medication, and end-of-life issues – directly involve deeply held moral and religious beliefs. Parents increasingly worry that schools, counselors, health care providers, and government institutions may affirm values, identities, or treatment approaches that conflict with the teachings of their faith and the values of their family.

Just as importantly, many parents fear that the legal framework itself increasingly encourages children to look outside the family for guidance and authority on deeply personal matters. Rather than strengthening communication between parents and children, the current system may incentivize secrecy, isolation from family involvement, and reliance upon government institutions and outside professionals as primary decision-makers.

These concerns are amplified by the growing role of schools and publicly funded institutions in areas traditionally reserved to parents. School-based health clinics, behavioral health programs, counseling services, social-emotional learning initiatives, and gender-related support systems now operate within a legal environment where confidentiality rules and minor consent laws can significantly limit parental knowledge and oversight.

Even where the law remains unclear, many parents reasonably fear that the practical effect is the same: schools, health care providers, and public institutions increasingly exercise influence over

the emotional, psychological, and moral development of children while parents are pushed to the margins.

For many New Mexicans, this reflects a broader cultural and political shift that has occurred gradually over many years. Policies that may once have been viewed as narrow exceptions have accumulated into a much larger restructuring of the relationship between families, children, and the state. In many respects, these changes have advanced with relatively little public awareness or civic engagement.

One of the most significant concerns repeatedly expressed by families and faith communities is that many parents simply do not realize how dramatically the law has changed until they personally encounter these issues through a school, health care provider, counselor, or public institution. By that point, parents often discover that their legal authority is far more limited than they believed.

This reality underscores the growing importance of civic engagement.

Laws governing parental rights, health care consent, education policy, and confidentiality are ultimately established through elections, legislation, administrative rulemaking, and judicial interpretation. When citizens disengage from the political process, policy decisions are increasingly shaped by activists, advocacy organizations, professional associations, and governmental institutions that may not share the values or priorities of many New Mexico families.

For people of faith and parents concerned about the direction of these policies, civic participation is no longer optional. Voting, engaging in local school board elections, participating in legislative debates, communicating with elected officials, monitoring school and health care policies, and remaining informed about changes in state law have become essential components of protecting parental authority and preserving the role of the family.

The issues addressed in this report are not merely partisan disputes. They concern foundational questions about who should guide children through some of the most formative decisions of their lives: parents and families, or increasingly distant institutions of the state.

As New Mexico continues debating the proper balance between health care access, minor autonomy, parental rights, and governmental authority, many families believe it is critical that parents remain informed, engaged, and active participants in shaping the laws and policies that will define the future of children and families across the state.

APPENDIX A
NEW MEXICO CONSENT AND DISCLOSURE STATUTES

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24-1-9. Capacity to consent to examination, preventive care and treatment for a sexually transmitted infection.

Any person regardless of age has the capacity to consent to an examination, preventive care and treatment by a licensed health care provider for any sexually transmitted infection.

History: 1953 Comp., § 12-34-9, enacted by Laws 1973, ch. 359, § 9; 1993, ch. 341, § 3; 2017, ch. 87, § 9; 2023, ch. 99, § 6.

ANNOTATIONS

The 2023 amendment, effective June 16, 2023, provided that any person, regardless of age, has the capacity to consent to preventive care by a licensed health care provider for any sexually transmitted infection; in the section heading, added "preventive care"; and after "consent to an examination", added "preventive care".

The 2017 amendment, effective June 16, 2017, made technical changes; in the catchline, deleted "disease" and added "infection", after "by a licensed", deleted "physician" and added "health care provider", and after "transmitted", deleted "disease" and added "infection".

The 1993 amendment, effective July 1, 1993, substituted "a sexually transmitted" for "venereal" in the catchline and "sexually transmitted" for "venereal" near the end of the section.

Law reviews. — For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M.L. Rev. 279 (1980).

24-1-9.3. Sexually transmitted infections; mandatory counseling.

No positive test result for a sexually transmitted infection shall be revealed to the person upon whom the test was performed without the person performing the test or the health facility at which the test was performed providing or referring that person for individual counseling about:

A. the meaning of the test results;

B. the possible need for additional testing;

C. the availability of appropriate health care services, including mental health care, social services and support services; and

D. the benefits of locating and counseling any individual by whom the infected person may have been exposed to the sexually transmitted infection and any individual whom the infected person may have exposed to the sexually transmitted infection.

History: 1978 Comp., § 24-1-9.3, enacted by Laws 1996, ch. 80, § 2; 2017, ch. 87, § 12.

ANNOTATIONS

The 2017 amendment, effective June, 16, 2017, replaced "disease" or "diseases" with "infection" or "infections" throughout the section; and in Subsection C, after "social", added "services".

24-1-9.4. Sexually transmitted infections; confidentiality.

A. Except as provided in Section 24-1-9.2 NMSA 1978, no person or the person's agents or employees who require or administer a test for sexually transmitted infections shall disclose the identity of any person upon whom a test is performed or the result of such a test in a manner that permits identification of the subject of the test, except to the following persons:

(1) the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

(2) any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

(3) an authorized agent, a credentialed or privileged physician or an employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

(4) the department of health and the centers for disease control and prevention of the United States public health service in accordance with reporting requirements for a diagnosed case of a sexually transmitted infection;

(5) a health facility or health care provider that procures, processes, distributes or uses:

(a) a human body part from a deceased person, with respect to medical information regarding that person;

(b) semen for the purpose of artificial insemination;

(c) blood or blood products for transfusion or injection; or

(d) human body parts for transplant with respect to medical information regarding the donor or recipient;

(6) health facility staff committees or accreditation or oversight review organizations that are conducting program monitoring, program evaluation or service reviews, as long as any identity remains confidential;

(7) authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

(8) for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

B. Whenever disclosure is made, it shall be accompanied by a statement in writing that includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom this information pertains or as otherwise permitted by law. A person who makes an unauthorized disclosure of this information is guilty of a

petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both.".

History: 1978 Comp., § 24-1-9.4, enacted by Laws 1996, ch. 80, § 3; 2017, ch. 87, § 13.

ANNOTATIONS

The 2017 amendment, effective June, 16, 2017, provided for a written statement regarding confidentiality that must accompany disclosures related to tests for sexually transmitted infections; replaced "disease" or "diseases" with "infection" or "infections" throughout the section; designated the previously undesignated introductory clause as Subsection A and redesignated former Subsections A through H as Paragraphs A(1) through A(8), respectively; in Paragraph A(5), designated former Paragraphs E(1) through E(4) as Subparagraphs A(5)(a) through A(5)(d), respectively; and added a new Subsection B.

24-1-13. Pregnancy; capacity to consent to examination and diagnosis.

Any person, regardless of age, has the capacity to consent to an examination and diagnosis by a licensed physician for pregnancy.

History: 1953 Comp., § 12-34-13, enacted by Laws 1973, ch. 359, § 13.

ANNOTATIONS

Cross references. — For standard serological test for syphilis for pregnant women, *see* 24-1-10 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability for incorrectly diagnosing existence or nature of pregnancy, 2 A.L.R.5th 769.

24-1-13.1. Pregnancy; prenatal, delivery and postnatal treatment to a female minor; capacity to consent.

A health care provider shall have the authority, within the limits of his license, to provide prenatal, delivery and postnatal care to a female minor. A female minor shall have the capacity to consent to prenatal, delivery and postnatal care by a licensed health care provider.

History: Laws 2001, ch. 314, § 1 and Laws 2001, ch. 327, § 1.

ANNOTATIONS

Compiler's notes. — Laws 2001, ch. 314, § 1 and Laws 2001, ch. 327, § 1 enacted identical new sections of law, effective June 15, 2001. The section was set out as enacted by Laws 2001, ch. 327, § 1. *See* 12-1-8 NMSA 1978.

Cross references. — For age of majority, *see* 28-6-1 NMSA 1978.

24-2B-2. Informed consent.

No person shall perform a test designed to identify the human immunodeficiency virus or its antigen or antibody without first obtaining the informed consent of the person upon whom the test is performed, except as provided in Section 24-2B-5, 24-2B-5.1, 24-2B-5.2 or 24-2B-5.3 NMSA 1978. Informed consent shall be preceded by an explanation of the test, including its purpose, potential uses and limitations and the meaning of its results. Consent need not be in writing if there is documentation in the medical record that the test has been explained and the consent has been obtained. The requirement for full pre-test counseling may be waived under the following circumstances:

A. the performance of a prenatal test to determine if the human immunodeficiency virus or its antigen is present in a pregnant woman; provided that the woman, or her authorized representative, after having been informed of the option to decline the human immunodeficiency virus test, may choose not to have the human immunodeficiency virus test performed as a part of the routine prenatal testing if she or her authorized representative provides a written statement as follows:

"I am aware that a test to identify the human immunodeficiency virus or its antigen or antibody is a part of routine prenatal testing. However, I voluntarily and knowingly choose not to have the human immunodeficiency virus test performed.

_____
(Name of patient or authorized representative)

_____
(Signature and date)."; or

B. when human immunodeficiency virus testing is part of routine medical care.

History: Laws 1989, ch. 227, § 2; 1993, ch. 107, § 2; 1996, ch. 80, § 7; 2000, ch. 36, § 1; 2007, ch. 108, § 1.

ANNOTATIONS

The 2007 amendment, effective June 15, 2007, provided that the requirement for immunodeficiency pre-test counseling may be waived if the human immunodeficiency virus test is part of routine medical care or if the test is performed as part of a routine prenatal test, unless the pregnant woman chooses not to have the test performed.

The 2000 amendment, effective May 17, 2000, inserted "or 24-2B-5.3" in the first sentence.

The 1996 amendment, effective July 1, 1996, inserted "or 24-2B-5.2 NMSA 1978" following "24-2B-5.1" and made a stylistic change in the first sentence.

The 1993 amendment, effective June 18, 1993, substituted "24-2B-5 or 24-2B-5.1 NMSA 1978" for "6 of the Human Immunodeficiency Virus Test Act" in the first sentence.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Damage action for HIV testing without consent of person tested, 77 A.L.R.5th 541.

24-2B-3. Substituted consent.

Informed consent shall be obtained from a legal guardian or other person authorized by law when the person is not competent. A minor shall have the capacity to give informed consent to have the human immunodeficiency virus test performed on himself.

History: Laws 1989, ch. 227, § 3.

24-2B-4. Mandatory counseling.

No positive test result shall be revealed to the person upon whom the test was performed without providing or referring that person for individual counseling about:

A. the meaning of the test results;

B. the possible need for additional testing;

C. the availability of appropriate health care services, including mental health care, social and support services; and

D. the benefits of locating and counseling any individual by whom the infected person may have been exposed to the human immunodeficiency virus and any individual whom the infected person may have exposed to the human immunodeficiency virus.

History: Laws 1989, ch. 227, § 4; 2013, ch. 72, § 1.

ANNOTATIONS

The 2013 amendment, effective March 29, 2013, eliminated the requirement that a person upon whom a positive immunodeficiency virus test has been performed be provided or referred to counseling; and after "performed without", deleted "the person performing the test or the health facility at which the test was performed".

24-2B-6. Confidentiality.

A. No person or the person's agents or employees who require or administer the test shall disclose the identity of any person upon whom a test is performed or the result of such a test in a manner that permits identification of the subject of the test, except to the following persons:

(1) the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

(2) any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

(3) an authorized agent, a credentialed or privileged physician or employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

(4) the department of health in accordance with reporting requirements established by regulation;

(5) the department of health for the purpose of providing partner services;

(6) a health facility or health care provider that procures, processes, distributes or uses:

(a) a human body part from a deceased person, with respect to medical information regarding that person;

(b) semen provided prior to the effective date of the Human Immunodeficiency Virus Test Act for the purpose of artificial insemination;

(c) blood or blood products for transfusion or injection; or

(d) human body parts for transplant with respect to medical information regarding the donor or recipient;

(7) health facility staff committees or accreditation or oversight review organizations that are conducting program monitoring, program evaluation or service reviews, so long as any identity remains confidential;

(8) authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

(9) for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

B. The department of health may disclose human immunodeficiency virus test results, including the identity of any person upon whom a test is performed:

(1) to the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

(2) to the person who ordered the test or that person's agents or employees;

(3) in the conduct of public health practice, to appropriate municipal, county, state, federal or tribal public health agencies having at least equivalent security and confidentiality standards for human immunodeficiency virus test results as maintained by the department of health; and

(4) to health care personnel where necessary to protect the health of the individual who is the subject of the test or an individual who was significantly exposed to the subject of the test, provided that the health care personnel first provide to the department of health for review relevant medical records or other written attestations that document the need for access to the person's confidential human immunodeficiency virus test results.

C. For the purposes of this section:

(1) "partner services" means a protocol that the department of health establishes by regulation similar to those protocols and regulations for other reportable sexually transmitted diseases for contacting individuals whom it identifies to be at risk of human immunodeficiency virus infection due to contact with an individual whom it has identified, through reporting made pursuant to Paragraph (4) or (5) of Subsection A of this section, as having been infected with human immunodeficiency virus;

(2) "test" means a procedure that definitively diagnoses the presence of human immunodeficiency virus infection, either through the detection of the virus itself or the detection of antibodies against the virus; and

(3) "public health practice" means a population-based activity or individual effort aimed primarily at the prevention of injury, disease or premature mortality or the promotion of health in a community, including:

(a) surveillance and response; and

(b) developing public health policy.

History: Laws 1989, ch. 227, § 6; 1997, ch. 214, § 1; 2010, ch. 4, § 1; 2013, ch. 72, § 2.

ANNOTATIONS

The 2013 amendment, effective March 29, 2013, authorized the department of health to disclose human immunodeficiency virus test results for the purpose of conducting human immunodeficiency virus surveillance, investigation and intervention; added Subsection B; and added Paragraph (3) of Subsection C.

The 2010 amendment, effective May 19, 2010, added Paragraph (5) of Subsection A, renumbered the succeeding paragraphs, and added Subsection B.

The 1997 amendment, effective June 20, 1997, rewrote Subsection D.

Law reviews. — For comment, "Sex, Lies, and Lawsuits: A New Mexico Physician's Duty to Warn Third Parties Who Unknowingly May Be At Risk of Contracting HIV From a Patient," see 26 N.M.L. Rev. 481 (1996).

Am. Jur. 2d, A.L.R. and C.J.S. references. — State statutes or regulations expressly governing disclosure of fact that person has tested positive for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), 12 A.L.R.5th 149.

24-7A-2. Advance health-care directives.

A. An adult or emancipated minor, while having capacity, has the right to make his or her own health-care decisions and may give an individual instruction. The instruction may be oral or written; if oral, it must be made by personally informing a health-care provider. The instruction may be limited to take effect only if a specified condition arises.

B. An adult or emancipated minor, while having capacity, may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity under the Uniform Health-Care Decisions Act or Article 5 of the Uniform Probate Code [Chapter 45, Article 5 NMSA 1978]. The power may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an owner, operator or employee of a health-care institution at which the principal is receiving care.

C. Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

D. Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent, shall be made according to the provisions of Section 11 [24-7A-11 NMSA 1978] of the Uniform Health-Care Decisions Act.

E. An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

F. A health-care decision made by an agent for a principal is effective without judicial approval.

G. A written advance health-care directive may include the individual's nomination of a guardian of the person.

History: Laws 1995, ch. 182, § 2.

24-7A-6.1. Life-sustaining treatment for unemancipated minors.

A. Except as otherwise provided by law, a parent or guardian of an unemancipated minor may make that minor's health-care decisions.

B. A parent or guardian of an unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment for the unemancipated minor, subject to the provisions of this section and the standards for surrogate decision-making for adults provided for in the Uniform Health-Care Decisions Act.

C. Subject to the provisions of Subsection B of this section, if an unemancipated minor has capacity sufficient to understand the nature of that unemancipated minor's medical condition, the risks and benefits of treatment and the contemplated decision to withhold or withdraw life-sustaining treatment, that unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment.

D. For purposes of Subsection C of this section, a determination of the mental and emotional capacity of an unemancipated minor shall be determined by two qualified health-care professionals, one of whom shall be the unemancipated minor's primary care practitioner and the other of whom shall be a health-care practitioner that works with unemancipated minors of the minor's age in the ordinary course of that health-care practitioner's practice. If the unemancipated minor lacks capacity due to mental illness or developmental disability, one of the qualified health-care professionals shall be a person whose training and expertise aid in the assessment of functional impairment.

E. If the unemancipated minor's primary care practitioner has reason to believe that a parent or guardian of an unemancipated minor, including a non-custodial parent, has not been informed of a decision to withhold or withdraw life-sustaining treatment, the primary care practitioner shall make reasonable efforts to determine if the uninformed parent or guardian has maintained substantial and continuous contact with the unemancipated minor and, if so, shall make reasonable efforts to notify that parent or guardian before implementing a decision.

F. If there is disagreement regarding the decision to withhold or withdraw life-sustaining treatment for an unemancipated minor, the provisions of Section 24-7A-11 NMSA 1978 shall apply.

History: Laws 1997, ch. 168, § 13; 2009, ch. 220, § 2; 2015, ch. 116, § 6.

ANNOTATIONS

The 2015 amendment, effective June 19, 2015, amended the Uniform Health-Care Decisions Act provision, relating to life-sustaining treatment of unemancipated minors, by substituting each reference to "primary physician" with "primary care practitioner"; in Subsection D, after "minor's primary", deleted "physician" and added "care practitioner", after "whom shall be a", deleted "physician" and added "health-care practitioner", after "ordinary course of that", deleted "physician's" and after "health-care", added "practitioner's"; and in Subsection E, after "minor's primary", deleted "physician" and added "care practitioner", and after "the primary", deleted "physician" and added "care practitioner".

The 2009 amendment, effective June 19, 2009, deleted former Subsection G, which defined "unemancipated minor".

24-7A-6.2. Consent to health care for certain minors fourteen years of age or older.

A. An unemancipated minor fourteen years of age or older who has capacity to consent may give consent for medically necessary health care; provided that the minor is:

(1) living apart from the minor's parents or legal guardian; or

(2) the parent of a child.

B. For purposes of this section, "medically necessary health care" means clinical and rehabilitative, physical, mental or behavioral health services that are:

(1) essential to prevent, diagnose or treat medical conditions or that are essential to enable an unemancipated minor to attain, maintain or regain functional capacity;

(2) delivered in the amount and setting with the duration and scope that is clinically appropriate to the specific physical, mental and behavioral health-care needs of the minor;

(3) provided within professionally accepted standards of practice and national guidelines; and

(4) required to meet the physical, mental and behavioral health needs of the minor, but not primarily required for convenience of the minor, health-care provider or payer.

C. The consent of the unemancipated minor to examination or treatment pursuant to this section shall not be disaffirmed because of minority.

D. The parent or legal guardian of an unemancipated minor who receives medically necessary health care is not liable for payment for those services unless the parent or legal guardian has consented to such medically necessary health care; provided that the provisions of this subsection do not relieve a parent or legal guardian of liability for payment for emergency health care provided to an unemancipated minor.

E. A health-care provider or a health-care institution shall not be liable for reasonably relying on statements made by an unemancipated minor that the minor is eligible to give consent pursuant to Subsection A of this section.

F. Nothing in this section shall otherwise limit the rights of an unemancipated minor to consent to treatment, nor shall this section be read to conflict with the rights of parents and children pursuant to the Children's Mental Health and Developmental Disabilities Act [32A-6A-1 to 32A-6A-30 NMSA 1978].

History: 1978 Comp., § 24-7A-6.2, as enacted by Laws 2009, ch. 220, § 3.

ANNOTATIONS

Effective dates. — Laws 2009, ch. 220 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 19, 2009, 90 days after the adjournment of the legislature.

24-8-2. Definitions.

As used in the Family Planning Act:

A. "contraceptive procedures" means any medically accepted procedure to prevent pregnancy;

B. "family planning services" includes contraceptive procedures and services (diagnosis, treatment, supplies and follow-up), social services, educational and informational services;

C. "health facility" means a hospital, clinic, nursing home, intermediate care facility or pharmacy;

D. "medically indigent" means a person who has insufficient funds to pay for family planning services;

E. "local governmental units" means counties, municipalities and public school districts and any of their agencies, departments, commissions, committees, institutions and educational institutions;

F. "physician" means a person licensed or authorized to practice medicine or osteopathy under the provisions of Sections 61-6-1 through 61-6-28 and 61-10-1 [repealed] through 61-10-21 NMSA 1978; and

G. "state" means the state and its agencies, departments, commissions, committees, institutions and educational institutions.

History: 1953 Comp., § 12-30-2, enacted by Laws 1973, ch. 107, § 2.

ANNOTATIONS

Bracketed material. — The bracketed material was inserted by the compiler and is not part of the law.

Laws 2016, ch. 90, § 29 repealed 61-10-1 NMSA 1978 effective July 1, 2016.

Law reviews. — For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M.L. Rev. 121 (1976-77).

24-8-5. Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services.

Neither the state, its local governmental units nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite to the receipt of any requested family planning service except for:

A. a requirement of referral to a physician or a physician assistant, advanced practice registered nurse or certified nurse-midwife working within that person's scope of practice when the requested family planning service is something other than information about family planning or nonprescription items;

B. any requirement imposed by law or regulation as a prerequisite to the receipt of a family planning service; or

C. payment for the service when payment is required in the ordinary course of providing the particular service to the person involved.

History: 1953 Comp., § 12-30-5, enacted by Laws 1973, ch. 107, § 5; 2015, ch. 116, § 10.

ANNOTATIONS

The 2015 amendment, effective June 19, 2015, amended the Family Planning Act provision, relating to the prohibition against imposition of standards and requirements as prerequisites for receipt of family planning services, by including other health care professionals with each reference to "physician"; in Subsection A, after "physician", added "or a physician assistant, advanced practice registered nurse or certified nurse-midwife working within that person's scope of practice".

Temporary provisions. — Laws 2015, ch. 116, § 16 provided that by January 1, 2016, every cabinet secretary, agency head and head of a political subdivision of the state shall update rules requiring an examination by, a certificate from or a statement of a licensed physician to also accept such examination, certificate or statement from an advanced practice registered nurse, certified nurse-midwife or physician assistant working within that person's scope of practice.

Law reviews. — For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M.L. Rev. 121 (1976-77).

For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M.L. Rev. 279 (1980).

24-10-1. Emancipated minors; hospital, medical and surgical care.

Notwithstanding any other provision of the law, and without limiting cases in which consent may otherwise be obtained or is not required, any emancipated minor or any minor who has contracted a lawful marriage may give consent to the furnishing of hospital, medical and surgical care to such minor, and the consent is not subject to disaffirmance because of minority. The consent of a parent of an emancipated minor or of a minor who has contracted a lawful marriage is not necessary in order to authorize hospital, medical and surgical care. For the purposes of this section only, subsequent judgment of annulment of the marriage or judgment of divorce shall not deprive the minor of his adult status once attained.

History: 1953 Comp., § 12-12-1, enacted by Laws 1963, ch. 32, § 1; recompiled as 1953 Comp., § 12-25-1, by Laws 1972, ch. 51, § 9.

ANNOTATIONS

Cross references. — For health care decisions, *see* Chapter 24, Article 7A NMSA 1978.

For age of majority, *see* 28-6-1 NMSA 1978.

For effect of minority upon limitations period for malpractice actions, *see* 41-5-13 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Power of courts or other public agencies, in the absence of statutory authority, to order compulsory medical care for adult, 9 A.L.R.3d 1391.

Voluntary acts: what voluntary acts of child, other than marriage or entry in military service, terminate parent's obligation to support, 32 A.L.R.3d 1055.

Medical practitioner's liability for treatment given child without parent's consent, 67 A.L.R.4th 511.

Power of court or other public agency to order medical treatment over parental religious objections for child whose life is not immediately endangered. 21 A.L.R.5th 248.

What voluntary acts of child, other than marriage or entry into military service, terminate parent's obligation to support, 55 A.L.R.5th 557.

42 C.J.S. Infants § 116.

24-10-2. Consent for emergency attention by person in loco parentis.

Notwithstanding any other provision of the law, in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting thereto, after reasonable efforts have been made under the circumstances, consent for the emergency attention may be given by any person standing in loco parentis to the minor.

History: 1953 Comp., § 12-12-2, enacted by Laws 1963, ch. 32, § 2; recompiled as 1953 Comp., § 12-25-2, by Laws 1972, ch. 51, § 9.

ANNOTATIONS

Cross references. — For age of majority, *see* 28-6-1 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 42 Am. Jur. 2d Infants §§ 16, 17, 55, 72; 59 Am. Jur. 2d Parent and Child §§ 11, 48, 74, 88.

Propriety of surgically invading incompetent or minor for benefit of third party, 4 A.L.R.5th 1000.

42 C.J.S. Infants §§ 93, 181.

24-10-6. Blood donation; minors.

A. A minor who is at least seventeen years of age may donate blood to a licensed, accredited or approved blood bank, storage facility or hospital without parental consent.

B. A minor shall not receive monetary payment from a licensed, accredited or approved blood bank, storage facility or hospital for a donation of blood or blood components.

History: Laws 2003, ch. 79, § 1.

ARTICLE 34
Reproductive and Gender-Affirming Health Care Freedom

24-34-1. Short title.

This act [24-34-1 to 24-34-5 NMSA 1978] may be cited as the "Reproductive and Gender-Affirming Health Care Freedom Act".

History: Laws 2023, ch. 11, § 1.

ANNOTATIONS

Effective dates. — Laws 2023, ch. 11 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 16, 2023, 90 days after adjournment of the legislature.

County and municipal officials exceeded their authority by enacting abortion-related ordinances preempted by state law. — Where several counties and municipalities (respondents) enacted local ordinances prohibiting the mailing or receipt of any abortion-related instrumentality and creating licensing schemes exclusive to abortion clinics and providers, and where the state of New Mexico sought a writ of mandamus and stay of respondents' enforcement of the ordinances and to invalidate the ordinances as preempted by state law, the writ of mandamus was granted because the ordinances plainly conflicted with the provisions of the reproductive and Gender-Affirming Health Care Freedom Act (act), which prohibits any public body, entity, or individual from interfering with access to reproductive or gender-affirming health care and from imposing penalties for violations of the act's provisions. *State ex rel. Torrez v. Bd. of Cnty. Comm'rs for Lea Cnty.*, 2025-NMSC-011.

24-34-2. Definitions.

As used in the Reproductive and Gender-Affirming Health Care Freedom Act:

A. "gender-affirming health care" means psychological, behavioral, surgical, pharmaceutical and medical care, services and supplies provided to support a person's gender identity;

B. "public body" means a state or local government, an advisory board, a commission, an agency or an entity created by the constitution of New Mexico or any branch of government that receives public funding, including political subdivisions, special tax districts, school districts and institutions of higher education; and

C. "reproductive health care" means psychological, behavioral, surgical, pharmaceutical and medical care, services and supplies that relate to the human reproductive system, including services related to:

(1) preventing a pregnancy;

(2) abortion;

(3) managing a pregnancy loss;

(4) prenatal, birth, perinatal and postpartum health;

(5) managing perimenopause and menopause;

(6) managing fertility;

(7) treating cancers of the reproductive system; or

(8) preventing or treating sexually transmitted infections.

History: Laws 2023, ch. 11, § 2.

ANNOTATIONS

Effective dates. — Laws 2023, ch. 11 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 16, 2023, 90 days after adjournment of the legislature.

24-34-3. Public body prohibited action.

A. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not discriminate against a person based on that person's use of or refusal to use reproductive health care or gender-affirming health care services.

B. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not deny, restrict or interfere with a person's ability to access or provide reproductive health care or gender-affirming health care within the medical standard of care.

C. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not deprive, through prosecution, punishment or other means, a person's ability to act or refrain from acting during the person's pregnancy based on the potential, actual or perceived effect on the pregnancy.

D. A public body or an entity or individual acting on behalf of or within the scope of the authority of a public body shall not impose or continue in effect any law, ordinance, policy or regulation that violates or conflicts with the provisions of the Reproductive and Gender-Affirming Health Care Freedom Act.

E. Nothing in the Reproductive and Gender-Affirming Health Care Freedom Act shall be construed to require a health care provider or entity to provide care:

(1) that the health care provider or entity does not otherwise provide or have a duty to provide under state or federal law;

(2) when the provision of service is against the medical judgment of the treating health care provider while acting within the standard of care; or

(3) when an individual does not provide payment or a source of payment for the service when it is required in the ordinary course of business, unless the health care provider has a duty to provide services under state or federal law, regardless of the ability to pay.

F. Nothing in the Reproductive and Gender-Affirming Health Care Freedom Act shall be construed to require a managed care organization or health insurance company to cover claims that are not otherwise

required to be covered by the terms and conditions of an insurance contract, managed care contract or state or federal law.

History: Laws 2023, ch. 11, § 3.

ANNOTATIONS

Effective dates. — Laws 2023, ch. 11 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 16, 2023, 90 days after adjournment of the legislature.

County and municipal officials exceeded their authority by enacting abortion-related ordinances preempted by state law. — Where several counties and municipalities (respondents) enacted local ordinances prohibiting the mailing or receipt of any abortion-related instrumentality and creating licensing schemes exclusive to abortion clinics and providers, and where the state of New Mexico sought a writ of mandamus and stay of respondents' enforcement of the ordinances and to invalidate the ordinances as preempted by state law, the writ of mandamus was granted because the ordinances plainly conflicted with the provisions of the Reproductive and Gender-Affirming Health Care Freedom Act (act), which prohibits any public body, entity, or individual from interfering with access to reproductive or gender-affirming health care and from imposing penalties for violations of the act's provisions. *State ex rel. Torrez v. Bd. of Cnty. Comm'rs for Lea Cnty.*, 2025-NMSC-011.

24-34-4. Enforcement; penalties.

A. The attorney general or a district attorney may institute a civil action in district court if the attorney general or district attorney has reasonable cause to believe that a violation has occurred or to prevent a violation of the Reproductive and Gender-Affirming Health Care Freedom Act from occurring.

B. In any action brought under Subsection A of this section, the court may award appropriate relief, including temporary, preliminary or permanent injunctive relief. The court may assess a civil penalty for a violation of the Reproductive and Gender-Affirming Health Care Freedom Act in the amount of five thousand dollars ($5,000) or actual damages resulting from each violation, whichever is greater.

C. Claims pursuant to the Reproductive and Gender- Affirming Health Care Freedom Act may be brought against public bodies and entities acting in the course and scope of authority of a public body, but not against an individual.

History: Laws 2023, ch. 11, § 4.

ANNOTATIONS

Effective dates. — Laws 2023, ch. 11 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 16, 2023, 90 days after adjournment of the legislature.

24-34-5. Private right of action.

A. A person claiming to be aggrieved by a violation of the Reproductive and Gender-Affirming Health Care Freedom Act may maintain an action in district court for appropriate relief, including temporary, preliminary or permanent injunctive relief, compensatory damages or punitive damages, or the sum of five thousand dollars ($5,000) for each violation of the Reproductive and Gender-Affirming Health Care Freedom Act, whichever is greater.

B. In any action brought pursuant to Subsection A of this section, the court shall award a prevailing plaintiff reasonable attorney fees and costs to be paid by the defendant.

C. Claims pursuant to the Reproductive and Gender-Affirming Health Care Freedom Act may be brought against public bodies and entities acting in the course and scope of authority of a public body, but not against an individual.

History: Laws 2023, ch. 11, § 5.

ANNOTATIONS

Effective dates. — Laws 2023, ch. 11 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 16, 2023, 90 days after adjournment of the legislature.

28-6-1. Age of majority; eighteen years; exception.

A. Except as provided in Subsection B or otherwise specifically provided by existing law, any person who has reached his eighteenth birthday shall be considered to have reached his majority as provided in Section 12-2-2 NMSA 1978 [repealed] and is an adult for all purposes the same as if he had reached his twenty-first birthday.

B. For the purposes of the Uniform Gifts to Minors Act [repealed], as it relates to any gift made prior to June 18, 1971, the donee shall not be entitled to delivery or payment over of the gift until he has reached his twenty-first birthday.

History: 1953 Comp., § 13-13-1, enacted by Laws 1971, ch. 213, § 1; 1973, ch. 138, § 12.

ANNOTATIONS

Bracketed material. — The bracketed material was inserted by the compiler and is not part of the law.

Section 12-2-2 NMSA 1978 was repealed in 1997. For comparable provisions, *see* 12-2A-3 NMSA 1978.

The Uniform Gifts to Minors Act, referred to in Subsection B, formerly appeared as 46-7-1 to 46-7-10 NMSA 1978, but was by repealed Laws 1989, ch. 357, § 26. For present comparable provisions, *see* the Uniform Transfers to Minors Act, 46-7-11 NMSA 1978 et seq.

Cross references. — For consent to prenatal, delivery and postnatal treatment, *see* 24-1-13.1 NMSA 1978.

For contributing to delinquency of minor, *see* 30-6-3 NMSA 1978.

For sexually oriented material harmful to minors, *see* 30-37-2 NMSA 1978.

For "adult" as person 18 years of age or over under Children's Code, *see* 32A-1-4 NMSA 1978.

For educational loans, legal disability of minors removed, *see* 58-6-3 NMSA 1978.

For alcoholic beverages, sale to person under 21 unlawful, identity cards, employment, *see* 60-7B-1 to 60-7B-11 NMSA 1978.

Section not unconstitutional. — Although trial court had continuing jurisdiction to modify divorce decree containing child custody provisions under the provisions of Section 40-4-7 NMSA 1978, that decree was considered final and not within the meaning of a "pending case" in N.M. Const., art. IV, § 34. Therefore, this section, which by its operation freed divorced father from making support payments to daughter who had reached age of 18, and thus, under the new section, was no longer a minor, is not unconstitutional. *Phelps v. Phelps*, 1973-NMSC-044, 85 N.M. 62, 509 P.2d 254.

Purpose of section. — The phrase "for all purposes" does not bar the right of parties to a contract to agree that "of full age" may be stipulated to mean 21 years; the purpose of the statute is to substitute the age of 18 for the age of 21 when any prior special law fixes an adult age of 21 years, subject to the specific exception of liquor control, and there is no analogical or interpretive basis for the contention that "for all purposes" means that a person 18 years of age is an adult in every phase of law, including the law of contracts and the modification of contracts. *Peterson v. Romero*, 1975-NMCA-127, 88 N.M. 483, 542 P.2d 434.

Effect of section on contracts where age stipulated. — Rental contract requiring that the rented vehicle be driven by "persons of full age (21 years)" was not modified by this section, and therefore neither car lessee nor estate of 18-year-old deceased driver were covered by the insurance provisions of the rental contract. *Peterson v. Romero*, 1975-NMCA-127, 88 N.M. 483, 542 P.2d 434.

On child-support payments. — Divorced husband was relieved by enactment of this statute from making further child-support payments under decree which required husband to make such payments during minority of his children or until they earlier become married or otherwise emancipated, where children were age 20 and 18 respectively. *Mason v. Mason*, 1973-NMSC-031, 84 N.M. 720, 507 P.2d 781.

Relation between age and voluntariness of confession. — Age is a factor to be considered in determining the voluntariness of a confession; however, a person who has reached the age of 18 is considered an adult for most purposes. *State v. Aguirre*, 1978-NMCA-029, 91 N.M. 672, 579 P.2d 798, cert. denied, 91 N.M. 751, 580 P.2d 972.

Law reviews. — For student article, "Tort Law — Either the Parents or the Child May Claim Compensation for the Child's Medical and Non-Medical Damages: Lopez v. Southwest Community Health Services," see 23 N.M.L. Rev. 373 (1993).

For symposium, "The Effects of an Equal Rights Amendment on the New Mexico System of Community Property: Problems of Characterization, Management and Control," see 3 N.M.L. Rev. 11 (1973).

For article, "Intestate Succession and Wills Law: The New Probate Code," see 6 N.M.L. Rev. 25 (1975).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 42 Am. Jur. 2d Infants § 4.

Inclusion or exclusion of the day of birth in computing one's age, 5 A.L.R.2d 1143.

Infant's liability for medical, dental, or hospital services, 53 A.L.R.4th 1249.

Statute protecting minors in a specified age range from rape or other sexual activity as applicable to defendant minor within protected age group, 18 A.L.R.5th 856.

43 C.J.S. Infants §§ 2, 3.

32A-4-2. Definitions.

As used in the Abuse and Neglect Act:

A. "abandonment" includes instances when the parent, without justifiable cause:

(1) left the child without provision for the child's identification for a period of fourteen days; or

(2) left the child with others, including the other parent or an agency, without provision for support and without communication for a period of:

(a) three months if the child was under six years of age at the commencement of the three-month period; or

(b) six months if the child was over six years of age at the commencement of the six-month period;

B. "abused child" means a child:

(1) who has suffered or who is at risk of suffering serious harm because of the action or inaction of the child's parent, guardian or custodian;

(2) who has suffered physical abuse, emotional abuse or psychological abuse inflicted or caused by the child's parent, guardian or custodian;

(3) who has suffered sexual abuse or sexual exploitation inflicted by the child's parent, guardian or custodian;

(4) whose parent, guardian or custodian has knowingly, intentionally or negligently placed the child in a situation that may endanger the child's life or health; or

(5) whose parent, guardian or custodian has knowingly or intentionally tortured, cruelly confined or cruelly punished the child;

C. "aggravated circumstances" includes those circumstances in which the parent, guardian or custodian has:

(1) attempted, conspired to cause or caused great bodily harm to the child or great bodily harm or death to the child's sibling;

(2) attempted, conspired to cause or caused great bodily harm or death to another parent, guardian or custodian of the child;

(3) attempted, conspired to subject or has subjected the child to torture, chronic abuse or sexual abuse; or

(4) had parental rights over a sibling of the child terminated involuntarily;

D. "educational decision maker" means an individual appointed by the children's court to attend school meetings and to make decisions about the child's education that a parent could make under law, including

decisions about the child's educational setting, and the development and implementation of an individual education plan for the child;

E. "fictive kin" means a person not related by birth, adoption or marriage with whom a child has an emotionally significant relationship;

F. "great bodily harm" means an injury to a person that creates a high probability of death, that causes serious disfigurement or that results in permanent or protracted loss or impairment of the function of a member or organ of the body;

G. "neglected child" means a child:

(1) who has been abandoned by the child's parent, guardian or custodian;

(2) who is without proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being because of the faults or habits of the child's parent, guardian or custodian or the failure or refusal of the parent, guardian or custodian, when able to do so, to provide them;

(3) who has been physically or sexually abused, when the child's parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm;

(4) whose parent, guardian or custodian is unable to discharge that person's responsibilities to and for the child because of incarceration, hospitalization or physical or mental disorder or incapacity; or

(5) who has been placed for care or adoption in violation of the law; provided that nothing in the Children's Code [Chapter 32A NMSA 1978] shall be construed to imply that a child who is being provided with treatment by spiritual means alone through prayer, in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof is for that reason alone a neglected child within the meaning of the Children's Code; and further provided that no child shall be denied the protection afforded to all children under the Children's Code;

H. "personal identifier information" means a person's name and contact information, including home or business address, email address or phone number;

I. "physical abuse" includes any case in which the child suffers strangulation or suffocation and any case in which the child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling or death and:

(1) there is not a justifiable explanation for the condition or death;

(2) the explanation given for the condition is at variance with the degree or nature of the condition;

(3) the explanation given for the death is at variance with the nature of the death; or

(4) circumstances indicate that the condition or death may not be the product of an accidental occurrence;

J. "relative" means a person related to another person by birth, adoption or marriage within the fifth degree of consanguinity;

K. "sexual abuse" includes criminal sexual contact, incest or criminal sexual penetration, as those acts are defined by state law;

L. "sexual exploitation" includes:

(1) allowing, permitting or encouraging a child to engage in prostitution;

(2) allowing, permitting, encouraging or engaging a child in obscene or pornographic photographing; or

(3) filming or depicting a child for obscene or pornographic commercial purposes, as those acts are defined by state law;

M. "sibling" means a brother or sister having one or both parents in common by birth or adoption;

N. "strangulation" has the same meaning as set forth in Section 30-3-11 NMSA 1978;

O. "suffocation" has the same meaning as set forth in Section 30-3-11 NMSA 1978; and

P. "transition plan" means an individualized written plan for a child, based on the unique needs of the child, that outlines all appropriate services to be provided to the child to increase independent living skills. The plan shall also include responsibilities of the child, and any other party as appropriate, to enable the child to be self-sufficient upon emancipation.

History: 1978 Comp., § 32A-4-2, enacted by Laws 1993, ch. 77, § 96; 1997, ch. 34, § 1; 1999, ch. 77, § 3; 2009, ch. 239, § 33; 2016, ch. 54, § 2; 2017, ch. 64, § 2; 2018, ch. 30, § 3; 2023, ch. 90, § 20; 2025, ch. 156, § 7.

ANNOTATIONS

The 2025 amendment, effective June 20, 2025, defined the term "personal identifier information" as used in the Abuse and Neglect Act; added a new Subsection H and redesignated former Subsections H through O as Subsections I through P, respectively.

The 2023 amendment, effective July 1. 2023, left the provisions of this section unamended.

The 2018 amendment, effective July 1, 2018, included "strangulation" and "suffocation" within the definition of "physical abuse", and added definitions of "strangulation" and "suffocation" to the Abuse and Neglect Act; in Subsection H, after "in which the child", added "suffers strangulation or suffocation and any case in which the child"; and added Subsections M and N.

The 2017 amendment, effective June 16, 2017, defined "educational decision maker" as used in the Abuse and Neglect Act; added a new Subsection D and redesignated former Subsections D through L as Subsections E through M, respectively; and in Subsections H, J and K, after "includes", deleted "but is not limited to".

The 2016 amendment, effective May 18, 2016, added "fictive kin", "relative" and "sibling" to the definitions section of the Abuse and Neglect Act; added new Subsection D and redesignated former Subsections D, E and F as Subsections E, F and G, respectively; added new Subsection H and redesignated former Subsections G and H as Subsections I and J, respectively; and added new Subsection K and redesignated the succeeding subsection accordingly.

The 2009 amendment, effective July 1, 2009, added Subsection I.

The 1999 amendment, effective July 1, 1999, deleted "but is not limited to" following "includes" in the introductory language of Subsection A; in Subsection B, in Paragraph (1), inserted "has suffered or who"

and added the language beginning "because of" to the end, and in Paragraph (2), inserted "or caused"; added Subsections C and D and redesignated the subsequent subsections accordingly; in Subsection E, in Paragraph (2), substituted "failure" for "neglect", and in Paragraph (4), deleted "other" following "hospitalization or".

The 1997 amendment, effective July 1, 1997, added Paragraph B(1) and redesignated former Paragraphs B(1) to (4) as Paragraphs B(2) to (5).

Decisions under prior law. — In light of the similarity of the provisions, annotations decided under former Section 32-1-3 NMSA 1978 have been included in the annotations to this section.

New Mexico's legal standard for neglect under 32A-4-2(G)(2) NMSA 1978. — Before a child is adjudicated neglected, the children, youth and families department must provide clear and convincing evidence that the child is without proper parental care and control necessary for the child's well-being and that the child's lack of proper parental care and control is because of the faults or habits of the child's parent or the failure or refusal of the child's parent to provide the necessary care or control. The legislature intended that to find a child to be without proper parental care and control necessary for the child's well-being such that the child must be removed from the family, the child must be subjected to circumstances that create a serious risk to the child's mental or physical health and safety, a risk that is likely to result in important or dangerous consequences for the child. *State ex rel. CYFD v. Heather S.*, 2025-NMSC-002, *rev'g* A-1-CA-38614, mem. op. (N.M. Ct. App. July 6, 2021) (nonprecedential).

The district court may aggregate evidence to determine whether the children, youth and families department has proven by clear and convincing evidence that a child is neglected. — While 32A-4-2(G)(2) NMSA 1978 does not contain express language permitting aggregation, the enumeration of multiple areas of proper parental care and control indicate that the district court is allowed to consider together evidence bearing on different areas of proper parental care and control in its determination of neglect. Where there are multiple failures to provide proper parental care or control, which alone may have been insufficient to rise to the level of neglect, the combined effect of these failures may be sufficient to constitute neglect under 32A-4-2(G)(2) NMSA 1978, but it remains the children, youth and families department's burden to provide by clear and convincing evidence that the combined effect left the child without proper parental care and control necessary for the child's well-being, and the child's neglect can be attributed to the fault or failure of the parent. *State ex rel. CYFD v. Heather S.*, 2025-NMSC-002, *rev'g* A-1-CA-38614, mem. op. (N.M. Ct. App. July 6, 2021) (nonprecedential).

Substantial evidence of a clear and convincing nature did not support the district court's adjudication of child as a neglected child as a matter of law. — In an abuse and neglect proceeding, the district court's findings that mother failed to meet child's medical needs, failed to protect child from domestic violence, failed to maintain a safe and stable home, and failed to meet child's educational needs were not supported by substantial evidence, because the evidence did not establish by clear and convincing evidence that child was without proper parental care and control necessary to address his medical needs but instead showed that mother consistently sought out support and treatment for child up until the time the children, youth and families department (CYFD) took child into custody, the district court was presented with a single incident of domestic violence for which child was not present and there was no evidence of any ongoing abuse, the CYFD failed to explain how any risk of harm rose to the level of a serious risk that was likely to result in important and dangerous consequences to child rather than a mere speculation of harm, and CYFD did not present clear and convincing evidence to show that mother's failure to satisfy child's educational needs was mother's fault and not due to circumstances beyond her control. *State ex rel. CYFD v. Heather S.*, 2025-NMSC-002, *rev'g* A-1-CA-38614, mem. op. (N.M. Ct. App. July 6, 2021) (nonprecedential).

The district court's adjudication of child as neglected was not supported by substantial evidence of a clear and convincing nature. — Where the children, youth and families department (CYFD) initiated an

investigation, which led to the filing of a petition for neglect and abuse against parents, based on a report from the hospital that the child's mother had tested positive for drug use, and where, during a home visit, the CYFD investigator observed cockroaches on the floor, the walls, the cabinets, the bed, the legs of the child's changing table, and on the table where the child's bottles and formula were kept, and where, following the establishment of a safety plan where the parents were required to address the condition of the home, the CYFD investigator, during a second home visit, observed that the cockroach situation had worsened, resulting in the child being taken into CYFD custody even though the child had not been in the parents' home during the second inspection and had remained safely at a relative's house throughout this period, and where, based on the CYFD investigator's testimony, the district court found clear and convincing evidence of neglect by the child's father, the district court's adjudication of neglect was not supported by substantial evidence of a clear and convincing nature where CYFD failed to establish that the child was subjected to circumstances that created a serious risk to the child's mental or physical health and safety or that any lack of proper parental care and control was because of the faults and habits of the father. *State ex rel. CYFD v. Anthony D.*, 2025-NMCA-015.

Standard of proof of abuse and neglect at adjudicatory hearing. — Where father's parental rights to his three children were terminated following the district court's adjudication of neglect, and where father argued that the federal Indian Child Welfare Act of 1978 (ICWA) and New Mexico state law require the district court at the adjudicatory hearing to find that father abused or neglected children by evidence beyond a reasonable doubt, rather than by clear and convincing evidence, the district court did not err in applying a clear and convincing standard of proof at the adjudicatory hearing, because proof of neglect or abuse at an adjudicatory hearing in an ICWA case in New Mexico is by clear and convincing evidence, and in this case, the district court properly found neglect by father under 32A-4-2(G)(2) NMSA 1978, at the adjudicatory hearing, applying the clear and convincing evidence standard of proof, and in contrast, made its finding of neglect at the termination of parental rights (TPR) hearing by evidence beyond a reasonable doubt. There was no error in these finding or in the standard of proof applied by the district court at either the adjudicatory hearing or the TPR hearing. *CYFD v. James M.*, 2023-NMCA-025, cert. denied.

Proof of perpetrator of child abuse. — Subsection B of Section 32A-4-2 NMSA 1978 does not require a specific determination of which parent's actions or inactions caused a child to be put at risk when adjudicating the child as abused and evidence that the abuse was perpetrated by either parent is sufficient for a court to conclude that the action or inaction of a parent caused the abuse and bring the case within the scope of the statute. *State ex rel. Children, Youth and Families Dep't v. Carl C.*, 2012-NMCA-065, 281 P.3d 1242.

Where the parents of a child were the primary caregivers of the child; the court found by clear and convincing evidence that one parent or the other parent, or both, had caused severe physical injuries to the child; and the court could not determine which parent specifically had been the perpetrator, the court did not err in adjudicating the child as abused without determining which parent actually caused the injuries suffered by the child. *State ex rel. Children, Youth and Families Dep't v. Carl C.*, 2012-NMCA-065, 281 P.3d 1242.

Act not unconstitutionally vague. — Abuse and Neglect Act is not unconstitutionally vague. *State ex rel. Children, Youth & Families Dept. v. Shawna C.*, 2005-NMCA-066, 137 N.M. 687, 114 P.3d 367.

Sufficient evidence of neglect. — Where the children lived with the mother; the father and the mother failed to see to the well-being, needs and support of the children; the father knew about the mother's propensities for drug abuse and domestic violence and knew or should have known about the children, youth and families department involvement with the children and the placement of the children with fictive kin; the father indicated to the department that he had no concerns regarding the care of the children; the father failed to respond to messages from the department and failed to appear at meetings with the department; the father was delinquent with child support; the father visited the children only once or twice a month; and the father made no effort to have the children live with him, the evidence was clear and

convincing that the father neglected the children. *State ex rel. Children, Youth & Families Dep't v. Cosme V.*, 2009-NMCA-094, 146 N.M. 809, 215 P.3d 747, cert. denied, 2009-NMCERT-007, 147 N.M. 361, 223 P.3d 358.

Sufficient evidence of neglect based on abandonment. — Where father was found by the district court to have neglected his child by abandoning her, and where father claimed that his lack of knowledge that the child's mother, who had custody of the infant, would neglect her, and that his lack of certain knowledge, through DNA testing, that he in fact was the father of the child negated any conclusion of abandonment under 32A-4-2(A)(2) NMSA 1978, the district court's determination that father had abandoned and thus neglected the child were supported by clear and convincing evidence, where the evidence demonstrated that father left the child in the care of mother without provision for support or communication, that the child was neglected while in mother's care, and that father was on notice and acknowledged that he was the father of the child. *State ex rel. CYFD v. Michael H.*, 2018-NMCA-032, cert. denied.

Insufficient evidence of neglect. — Evidence that the newborn child's initial toxicology test was positive, that the mother admitted to using narcotics and marijuana during her pregnancy, and that the mother left the child in the care of nurses while she left the hospital to smoke was insufficient to make the child neglected because of the mother's intentional or negligent disregard of the child's wellbeing and proper needs. *State ex rel., Children, Youth & Families Dep't v. Amanda H.*, 2007-NMCA-029, 141 N.M. 299, 154 P.3d 674.

Evidence that the mother of a newborn child had a long history of drug abuse, a criminal history and a history of violence was insufficient to show that the mother was actually unable to provide proper parental care or discharge her responsibilities to the child. *State ex rel., Children, Youth & Families Dep't v. Amanda H.*, 2007-NMCA-029, 141 N.M. 299, 154 P.3d 674.

Insufficient evidence of mental disorder or incapacity. — Where the legislature intended mental incapacity to encompass those circumstances in which an individual, due to an intellectual disability, is unable, as opposed to unwilling, to discharge his or her responsibilities to a child, the district court's conclusion that child was neglected pursuant to 32A-4-2E(4) NMSA 1978 was not supported by the evidence when the district court did not make any findings that mother suffered from a mental disorder or illness, nor did it find that mother suffered from mental incapacity, but explicitly found that mother was capable of learning and mastering information, but that her defiant attitude was affecting her ability to recognize the conditions she needed to improve in order to safely parent child. The district court erred in concluding that child was neglected pursuant to 32A-4-2E(4) and in concluding that the children, youth and families department established by clear and convincing evidence that a mental disorder or incapacity caused mother's inability to discharge her responsibilities to child. *State ex rel. CYFD v. Christina L.*, 2015-NMCA-115.

"Abandonment". — Parent abandoned children when parent left children in the care of their other parent, when the parent knew about drugs and had neglected the children; parent offered very little support to children before becoming incarcerated and then squandered any opportunity to be present in the children's lives by violating probation and becoming incarcerated; and while in prison, parent made no attempts to contact or support the children or to ensure their safety. *State ex rel. Children, Youth & Families Dep't v. William M.*, 2007-NMCA-055, 141 N.M. 705, 161 P.3d 262.

"Abused child". — Prior to its amendment in 1997, the definition of "abused child," did not permit the children's court to adjudicate a child abused or neglected where there was no evidence that the parent, guardian or custodian was responsible for the abuse or neglect. *State ex rel. Children, Youth & Families Dep't v. Vincent L.*, 1998-NMCA-089, 125 N.M. 452, 963 P.2d 529, cert. denied, 125 N.M. 654, 964 P.2d 818.

Proof that a child's sibling was abused, in and of itself, does not render the child endangered. — Where parents appealed the district court's adjudication of abuse against parent's son (child), based on the

endangerment definition of "abused child" in § 32A-4-2(B)(4) NMSA 1978, and on the court's finding of aggravated circumstances under § 32A-4-2(C)(1), the district court erred in its finding of abuse, because the children, youth and families department (CYFD) did not meet its burden to prove by clear and convincing evidence that the parents' child was an "abused child" under § 32A-4-2(B)(4). CYFD's contention that the child's sibling was physically abused in and of itself is insufficient to support a finding that the child was "abused" or is endangered under § 32A-4-2(B)(4). *CYFD v. Carmella M.*, 2022-NMCA-052.

"Abused and neglected". — Where parent left the children unattended for long periods of time, exposed them to dangerous situations, failed to understand their physical and emotional needs, failed to empathize with their feelings, was self-centered in the parent's interactions with them, exposed them to domestic violence, exposed them to substance abuse, showed an indifference to their needs in favor of the parent's own needs, and placed them with inappropriate caretakers, the children were abused and neglected. *In re Termination of Parental Rights of Eventyr J.*, 1995-NMCA-087, 120 N.M. 463, 902 P.2d 1066 (Ct. 108), cert. denied 120 N.M. 394, 902 P.2d 76.

"Aggravated circumstances". — Sections 32A-4-2C, 32A-4-22C, 32A-4-28B(2) NMSA 1978 are constitutional facially and as applied to a mother, whose parental rights were terminated without the state making reasonable efforts toward family reunification, where the mother had previously had parental rights terminated as to another child and no progress was evident in the mother's efforts to kick a 4-year drug abuse problem. *State ex rel. Children, Youth & Families Dep't v. Amy B.*, 2003-NMCA-017, 133 N.M. 136, 61 P.3d 845.

Where parent left the children in the care of another, was involved in criminal activity, became unavailable due to parent's incarceration, substance abuse was present in the home, and parent failed to maintain a relationship with the children, aggravating circumstances existed. *State ex rel. Children, Youth & Families Dep't v. William M.*, 2007-NMCA-055, 161 P.3d 262.

Where mother emphasized that she has not abused child and has not had an opportunity to actually demonstrate her parenting skills with child, and while true, the court noted that she has had an opportunity to demonstrate her abilities with five older children, and her admission of involuntary termination of her parental rights to those older children operates as clear and convincing proof of that fact, while this fact is not determinative for a finding of abuse and neglect, it is considered an aggravated circumstance under the Abuse and Neglect Act in the context of termination of parental rights. *State ex rel. Children, Youth & Families Dept. v. Shawna C.*, 2005-NMCA-066, 137 N.M. 687, 114 P.3d 367.

Stepfather as "custodian". — A stepfather meets the definition of "custodian" for purposes of the court's subject matter jurisdiction over him in a proceeding on a petition alleging abuse or neglect of a child. *In re Candice Y.*, 2000-NMCA-035, 128 N.M. 813, 999 P.2d 1045, cert. denied, 129 N.M. 207, 4 P.3d 35.

"Neglected". — Parent neglected children through parent's failure to be involved in the children's lives prior to parent's incarceration, failure to provide a safe and stable home by dealing drugs in the home, parent's decision to leave the children's home when they were very young, parent's decision to violate the terms of parent's probation resulting in parent's incarceration, and parent's failure to provide for the children or protect them from the other parent's neglect both prior to and during parent's incarceration. *State ex rel. Children, Youth & Families Dep't v. William M.*, 2007-NMCA-055, 141 N.M. 765, 161 P.3d 262.

Although low IQ, mental disability, or mental illness alone are not sufficient grounds for a finding of abuse or neglect where mother was unable to effectively parent due to her mental disorder and incapacity, this finding meets the definition of neglect under Subsection E(4) of this section. *State ex rel. Children, Youth & Families Dept. v. Shawna C.*, 2005-NMCA-066, 137 N.M. 687, 114 P.3d 367.

Evidence that a mother left her children in the care at their grandparents presented insufficient evidence to prove that mother was unfit to care for her children and failed to show that the children were "neglected"

under Paragraph E(2), where mother left the children with the grandparents for extended periods of time but she visited them and had them to her various residences on a regular basis. *In re Guardianship of Ashleigh R.*, 2002-NMCA-103, 132 N.M. 772, 55 P.3d 984, cert. denied, 132 N.M. 732, 55 P.3d 428.

Neglect of psychological needs. — The New Mexico Children's Code's definition of a "neglected child" is subject to broad interpretation and arguably encompasses situations where the child's psychological needs are neglected. *Martinez v. Mafchir*, 35 F.3d 1486 (10th Cir. 1994).

Definition of "sexual abuse" constitutional. — The definition of "sexual abuse" in this section is not unconstitutionally vague as applied to defendant's conduct which fit squarely within the specifically prohibited conduct, namely criminal sexual contact of a minor. *In re Candice Y.*, 2000-NMCA-035, 128 N.M. 813, 999 P.2d 1045, cert. denied, 129 N.M. 207, 4 P.3d 35.

Retardation evidence not required for ruling on neglect. — In a neglect proceeding, evidence that a child is severely retarded is not required for a ruling that the child is neglected. *State ex rel. Health & Soc. Servs. Dep't v. Natural Father*, 1979-NMCA-090, 93 N.M. 222, 598 P.2d 1182.

Incarceration. — Even though incarceration alone is not an appropriate reason to terminate parental rights, where the father was convicted of the murder of the mother, his subsequent long-term incarceration was sufficient to establish that the child was neglected, and that termination of his parental rights was justified. *State ex rel. Children, Youth & Families Dep't v. Joe R.*, 1997-NMSC-038, 123 N.M. 711, 945 P.2d 76.

Law reviews. — For comment, "The Freedom of the Press vs. The Confidentiality Provisions in the New Mexico Children's Code," see 4 N.M.L. Rev. 119 (1973).

For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M.L. Rev. 279 (1980).

For note, "Children's Code - Neglect - State ex rel. Health & Social Services Department v. Natural Father," see 12 N.M.L. Rev. 505 (1982).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Power of court or other public agency to order medical treatment for child over parental objections not based on religious grounds, 97 A.L.R.3d 421.

32A-4-3. Duty to report child abuse and child neglect; responsibility to investigate child abuse or neglect; penalty; notification of plan of safe care.

A. Every person, including a licensed physician; a resident or an intern examining, attending or treating a child; a law enforcement officer; a judge presiding during a proceeding; a registered nurse; a visiting nurse; a school employee; a social worker acting in an official capacity; or a member of the clergy who has information that is not privileged as a matter of law, who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately to:

(1) a local law enforcement agency;

(2) the department; or

(3) a tribal law enforcement or social services agency for any Indian child residing in Indian country.

B. A law enforcement agency receiving the report shall immediately transmit the facts of the report and the name, address and phone number of the reporter by telephone to the department and shall transmit the same information in writing within forty-eight hours. The department shall immediately transmit the facts of the report and the name, address and phone number of the reporter by telephone to a local law enforcement agency and shall transmit the same information in writing within forty-eight hours. The written report shall contain the names and addresses of the child and the child's parents, guardian or custodian, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the person responsible for the injuries. The written report shall be submitted upon a standardized form agreed to by the law enforcement agency and the department.

C. The recipient of a report under Subsection A of this section shall take immediate steps to ensure prompt investigation of the report. The investigation shall ensure that immediate steps are taken to protect the health or welfare of the alleged abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect. A local law enforcement officer trained in the investigation of child abuse and neglect is responsible for investigating reports of alleged child abuse or neglect at schools, daycare facilities or child care facilities.

D. If the child alleged to be abused or neglected is in the care or control of or in a facility administratively connected to the department, the report shall be investigated by a local law enforcement officer trained in the investigation of child abuse and neglect. The investigation shall ensure that immediate steps are taken to protect the health or welfare of the alleged abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.

E. A law enforcement agency or the department shall have access to any of the records pertaining to a child abuse or neglect case maintained by any of the persons enumerated in Subsection A of this section, except as otherwise provided in the Abuse and Neglect Act.

F. A person who violates the provisions of Subsection A of this section is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978.

G. A finding that a pregnant woman is using or abusing drugs made pursuant to an interview, self-report, clinical observation or routine toxicology screen shall not alone form a sufficient basis to report child abuse or neglect to the department pursuant to Subsection A of this section. A volunteer, contractor or staff of a

hospital or freestanding birthing center shall not make a report based solely on that finding and shall make a notification pursuant to Subsection H of this section. Nothing in this subsection shall be construed to prevent a person from reporting to the department a reasonable suspicion that a child is an abused or neglected child based on other criteria as defined by Section 32A-4-2 NMSA 1978, or a combination of criteria that includes a finding pursuant to this subsection.

H. A contractor or staff of a hospital, freestanding birthing center or clinic that provides prenatal or perinatal care shall:

(1) complete a written plan of safe care for a substance-exposed newborn or a pregnant person who agrees to creating a plan of safe care, as provided for by department rule and the Children's Code; and

(2) provide notification to the health care authority. Notification by a health care provider pursuant to this paragraph shall not be construed as a report of child abuse or neglect.

I. As used in this section, "notification" means informing the health care authority that a substance-exposed newborn was born and providing a copy of the plan of safe care that was created for the child; provided that notification shall comply with federal guidelines and shall not constitute a report of child abuse or neglect. The health care authority shall be responsible for ensuring compliance with federal reporting requirements related to plans of safe care.

J. As used in this section, "school employee" includes employees of a school district or a public school.

History: 1978 Comp., § 32A-4-3, enacted by Laws 1993, ch. 77, § 97; 1997, ch. 34, § 2; 2003, ch. 189, § 1; 2005, ch. 189, § 38; 2019, ch. 190, § 2; 2021, ch. 94, § 10; 2025, ch. 156, § 8.

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The 2025 amendment, effective June 20, 2025, provided that the health care authority is responsible for ensuring compliance with federal reporting requirements related to plans of safe care, and made technical amendments; in Subsection H, in the introductory clause, after "birthing center" added "or clinic that provides prenatal or perinatal care", in Paragraph H(1), after "substance-exposed newborn" added "or a pregnant person who agrees to creating a plan of safe care", in Paragraph H(2), after "notification to the" deleted "department" and added "health care authority"; and in Subsection I, after "informing the" deleted "department" and added "health care authority", and after "report of child abuse or neglect" added "The health care authority shall be responsible for ensuring compliance with federal reporting requirements related to plans of safe care.".

The 2021 amendment, effective June 18, 2021, defined "school employee" as used in this section; in Subsection A, after "visiting nurse; a", deleted "schoolteacher; a school official" and added "school employee"; and added Subsection J.

The 2019 amendment, effective June 14, 2019, provided that a finding that a pregnant woman is using or abusing drugs shall not alone form a sufficient basis to report child abuse or neglect, required volunteers, contractors or staff of a hospital or freestanding birthing center to complete a written plan of care for a substance-exposed newborn and to provide notification to the children, youth and families department that a substance-exposed newborn was born; in the section heading, after "penalty", added "notification of plan of care"; and added Subsections G through I.

The 2005 amendment, effective June 17, 2005, deleted the requirement in Subsections A and B that reports be made to the department office in the county where the child resides; and provided in Subsections

C and D that a law enforcement officer trained in the investigation of child abuse and neglect is responsible for investigating reports of abuse and neglect.

The 2003 amendment, effective July 1, 2003, in Subsection A, deleted "but not limited to" near the beginning, inserted "or a member of the clergy who has information that is not privileged as a matter of law" following "an official capacity"; substituted "agency" for "agencies" in Paragaraph A(3); substituted "A department office" for "Any office of the department" preceding "receiving a report" in Subsection B.

The 1997 amendment, effective July 1, 1997, inserted "responsibility to investigate child abuse or neglect" in the section heading, deleted "or persons" following "person" in the next-to-last sentence in Subsection B, substituted "alleged abused" for "abused" in the second sentence in Subsection C and in the second sentence in Subsection D, added the third sentence in Subsection C, deleted former Subsection D relating to abuse or neglect of a child while in the care of a child care facility or family day care home, redesignated former Subsections E to G as Subsections D to F, and substituted "by local law enforcement" for "through the office of the district attorney" at the end of the first sentence in Subsection D.

Decisions under prior law. — In light of the similarity of the provisions, annotations decided under former Section 32-1-15 NMSA 1978 have been included in the annotations to this section.

Scope of duty to report child abuse. — The child abuse reporting requirement of this section expressly applies to "every person," and although the statute lists specific occupational groups, the language of the statute expressly emphasizes that the list is not exclusive. *State v. Strauch*, 2015-NMSC-009, *rev'g* 2014-NMCA-020.

Statements made by an alleged child abuser to his social worker therapist, a mandated reporter under the Abuse and Neglect Act, are not protected from disclosure in a court proceeding as a result of the specific exception to the physician-patient and psychotherapist-patient evidentiary privilege in Rule 11-504(D)(4) NMRA, which provides that no privilege shall apply for confidential communications concerning any material that a social worker is required by law to report to a public employee or public agency. *State v. Strauch*, 2015-NMSC-009, *rev'g* 2014-NMCA-020.

"Official capacity" defined. — The language "acting in an official capacity" as set forth in Subsection A of this section is synonymous with acting in a "professional capacity", and is used to distinguish between child abuse knowledge gained through activities in the listed occupations and knowledge gained in other capacities. *State v. Strauch*, 2015-NMSC-009, *rev'g* 2014-NMCA-020.

Scope of duty to report child abuse. — The statutory requirement to report child abuse does not apply to every person, but instead applies to the categories of people listed in Section 32A-4-3(A) NMSA 1979 and other professionals or government officials who are likely to come into contact with abused and neglected children during the course of their professional work. *State v. Strauch*, 2014-NMCA-020, cert. granted, 2014-NMCERT-001.

Duty of social workers to report child abuse. — The mandatory reporting requirement set forth in Section 32A-4-3(A) NMSA 1978 applies principally to social workers in school and other governmental settings. *State v. Strauch*, 2014-NMCA-020, cert. granted, 2014-NMCERT-001.

Social worker acting as a private mental health provider. — Where defendant, who was charged with criminal sexual penetration of a minor, made confidential communications to a licensed social worker during private counseling sessions for the purpose of diagnosis and treatment; and defendant's ex-spouse participated in the counseling sessions, defendant had the privilege pursuant to Rule 11-504 NMRA to refuse to disclose and to prevent the social worker and defendant's ex-spouse from disclosing information defendant communicated during the counseling sessions because the mandatory reporting requirement in

Section 32A-4-3(A) NMSA did not apply to the social worker or to defendant's ex-spouse. *State v. Strauch*, 2014-NMCA-020, cert. granted, 2014-NMCERT-001.

Dismissals from human services department [health care authority department] were in accordance with law and supported by substantial evidence, which included the failure to promptly report the alleged sexual abuse of a child to the proper authorities. *Perkins v. Dep't of Human Servs.*, 1987-NMCA-148, 106 N.M. 651, 748 P.2d 24.

Requirement of "consultation" in Section 32-1-15 NMSA 1978 is not due process pre-deprivation hearing requirement, and plaintiff day-care center operator's constitutional right to due process was not violated by the human services department's [health care authority department's] transfer of state subsidized children to other facilities and suspension of federal funds pending completion of an investigation. *Rice v. Vigil*, 642 F. Supp. 212 (D.N.M. 1986), *aff'd sub nom. Rice v. N. M.*, 854 F.2d 1323 (10th Cir. 1988).

Law reviews. — For comment, "The Freedom of the Press vs. The Confidentiality Provisions in the New Mexico Children's Code," see 4 N.M.L. Rev. 119 (1973).

For article, "Salt in the Wounds: Why Attorneys Should Not be Mandated Reporters of Child Abuse", *see* 36 N.M. L. Rev. 125 (2006).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 42 Am. Jur. 2d Infants § 16.

Criminal liability for excessive or improper punishment inflicted on child by parent, teacher, or one in loco parentis, 89 A.L.R.2d 396.

Sexual abuse of child by parent as ground for termination of parent's right to child, 58 A.L.R.3d 1074.

Parent's involuntary confinement, or failure to care for child as result thereof, as evincing neglect, unfitness or the like in dependency or divestiture proceeding, 79 A.L.R.3d 417.

Admissibility of expert medical testimony on battered child syndrome, 98 A.L.R.3d 306.

Validity and construction of penal statute prohibiting child abuse, 1 A.L.R.4th 38.

Validity, construction, and application of state statute requiring doctor or other person to report child abuse, 73 A.L.R.4th 782.

Physical examination of child's body for evidence of abuse as violative of Fourth Amendment or as raising Fourth Amendment issue, 93 A.L.R. Fed. 530.

43 C.J.S. Infants § 14.

32A-6A-14. Consent for services; children under fourteen years of age.

A. Except as provided in Subsection B of this section, the informed consent of a child's legal custodian shall be required before treatment or habilitation, including psychotherapy or psychotropic medications, is administered to a child under fourteen years of age.

B. A child under fourteen years of age may initiate and consent to an initial assessment with a clinician and for medically necessary early intervention service limited to verbal therapy as set forth in this section. The purpose of the initial assessment is to allow a clinician to interview the child and determine what, if any, action needs to be taken to ensure appropriate mental health or habilitation services are provided to the child. The clinician may conduct an initial assessment and provide medically necessary early intervention service limited to verbal therapy with or without the consent of the legal custodian if such service will not extend beyond two calendar weeks. If, at any time, the clinician has a reasonable suspicion that the child is an abused or neglected child, the clinician shall immediately make a child abuse and neglect report.

History: Laws 2007, ch. 162, § 14.

ANNOTATIONS

Cross references. — For provisions of the 1995 Children's Mental Health and Developmental Disabilities Act, relating to right to education, *see* the 2006 NMSA 1978 (32A-6-7) on *NMOneSource.com.*

Effective dates. — Laws 2007, ch. 162 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 15, 2007, 90 days after the adjournment of the legislature.

Educational services. — Public schools have no constitutional or statutory obligation to provide educational services to students within private, for-profit adolescent psychiatric care and substance abuse treatment centers, but if the student is handicapped, federal law may require such education. 1988 Op. Att'y Gen. No. 88-10.

Law reviews. — For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M.L. Rev. 279 (1980).

32A-6A-15. Consent for services; children fourteen years of age or older.

A. A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions. Nothing in this section shall be interpreted to provide a child fourteen years of age or older with independent consent rights for the purposes of the provision of special education and related services as set forth in federal law.

B. Psychotropic medications may be administered to a child fourteen years of age or older with the informed consent of the child. When psychotropic medications are administered to a child fourteen years of age or older, the child's legal custodian shall be notified by the clinician.

C. A clinician or other mental health and developmental disabilities professional shall promote the healthy involvement of a child's legal custodians and family members in developing and implementing the child's treatment plan, including appropriate participation in treatment for children fourteen years of age or older. However, nothing in this section shall limit the rights of a child fourteen years of age or older to consent to services and to consent to disclosure of mental health records.

History: Laws 2007, ch. 162, § 15.

ANNOTATIONS

Effective dates. — Laws 2007, ch. 162 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 15, 2007, 90 days after the adjournment of the legislature.

32A-6A-16. Consent for services; determination of capacity for children fourteen years of age or older.

A. When a child fourteen years of age or older has been determined according to the provisions of this section to lack capacity, the child's legal custodian may make a mental health or habilitation decision for the child unless the child objects to such decision or the legal custodian's assumption of authority to make mental health or developmental disability treatment decisions or determination of lack of capacity. Nothing in this subsection:

(1) permits a legal custodian to consent to placement of a child in a residential treatment or habilitation program without the proper consent of the child if the child is fourteen years of age or older; or

(2) in any way, limits a child's right to involuntary commitment procedures as set forth in the Children's Mental Health and Developmental Disabilities Act.

B. The determination that a child fourteen years of age or older lacks or has recovered capacity shall be made by two clinicians, one of whom shall be a person who works with children in the ordinary course of that clinician's practice.

C. A child fourteen years of age or older shall not be determined to lack capacity solely on the basis that the child chooses not to accept the treatment recommended by the mental health or developmental disabilities professional.

D. A child fourteen years of age or older may at any time contest a determination that the child lacks capacity by a signed writing or by personally informing a clinician that the determination is contested. A clinician who is informed by a child that such determination is contested shall promptly communicate that the determination is contested to any supervising provider or institution at which the child is receiving care. Such a challenge shall prevail unless otherwise ordered by the court in a proceeding brought pursuant to the treatment guardianship provisions of the Children's Mental Health and Developmental Disabilities Act.

E. A determination of lack of capacity under the Children's Mental Health and Developmental Disabilities Act shall not be evidence of incapacity for any other purpose.

F. The legal custodian shall communicate an assumption of authority as promptly as practicable to the child fourteen years of age or older and to the clinician and to the supervising mental health or developmental disability treatment and habilitation provider.

G. If more than one legal custodian assumes authority to act as an agent, the consent of both shall be required for nonemergency treatment. In an emergency, the consent of one legal custodian is sufficient, but the treating mental health professional shall provide the other legal custodian with oral notice followed by written documentation.

H. If more than one legal custodian assumes authority to act as an agent and the legal custodians do not agree on a nonemergency mental health treatment decision and the clinician is so informed, the clinician shall not treat the child unless a treatment guardian is appointed pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act.

I. A legal custodian shall make treatment decisions in accordance with a child's individual instructions, if any, and other wishes to the extent known to the legal custodian. Otherwise, the legal custodian shall make

decisions in accordance with the legal custodian's determination of the child's best interests. In determining the child's best interests, the legal custodian shall consider the child's personal values to the extent known to the legal custodian.

J. A mental health treatment decision made by a legal custodian for a child fourteen years of age or older who has been determined to lack capacity shall not be made solely on the basis of the child's pre-existing physical or medical condition or pre-existing or projected disability.

K. A mental health treatment decision made by a legal custodian for a child fourteen years of age or older who has been determined to lack capacity is effective without judicial approval unless contested by the child.

L. If no legal custodian or agent is reasonably available to make mental health or habilitation decisions for the child, any interested party may petition for the appointment of a treatment guardian.

History: Laws 2007, ch. 162, § 16.

ANNOTATIONS

Effective dates. — Laws 2007, ch. 162 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 15, 2007, 90 days after the adjournment of the legislature.

32A-6A-20. Consent to placement in a residential treatment or habilitation program; children younger than fourteen years of age.

A. A child younger than fourteen years of age shall not receive residential treatment for a mental disorder or habilitation for a developmental disability, except as provided in this section.

B. A child younger than fourteen years of age may be admitted to a residential treatment or habilitation program for a period not to exceed sixty days with the informed consent of the child's legal custodian, subject to the requirements of this section.

C. In order to admit a child younger than fourteen years of age to a residential treatment or habilitation program, the child's legal custodian shall knowingly and voluntarily execute a consent to admission document prior to the child's admission. The consent to admission document shall be in a form designated by the supreme court. The consent to admission document shall include a clear statement of the legal custodian's right to consent voluntarily to or refuse the child's admission, the legal custodian's right to request the child's immediate discharge from the residential treatment program at any time and the legal custodian's rights when the legal custodian requests the child's discharge and the child's physician, licensed psychologist or the director of the residential treatment or habilitation program determines that the child needs continued treatment. The residential treatment or habilitation program shall ensure that each statement is clearly explained in the child's and legal custodian's primary language, if that is their language of preference, and in a manner appropriate to the child's and legal custodian's developmental abilities. Each statement shall be initialed by the child's legal custodian.

D. The legal custodian's executed consent to admission document shall be filed with the child's treatment records within twenty-four hours of the time of admission.

E. Upon the filing of the legal custodian's consent to admission document in the child's hospital records, the director of the residential treatment or habilitation program or the director's designee shall, on the next business day following the child's admission, notify the district court or the special commissioner appointed pursuant to Section 32A-6A-25 NMSA 1978 regarding the admission and provide the child's name, date of birth and the date and place of admission. The court or special commissioner shall, upon receipt of notice regarding a child's admission to a residential treatment or habilitation program, establish a sequestered court file.

F. The director of a residential treatment or habilitation program or the director's designee shall, on the next business day following the child's admission, petition the court to appoint a guardian ad litem for the child. When the court receives the petition, the court shall appoint a guardian ad litem.

G. Within seven days of a child's admission to a residential treatment or habilitation program, a guardian ad litem, representing the child's best interests and in accordance with the provisions of the Children's Mental Health and Developmental Disabilities Act [32A-6A-1 to 32A-6A-30 NMSA 1978], shall meet with the child, the child's legal custodian and the child's clinician. The guardian ad litem shall determine the following:

(1) whether the child's legal custodian understands and consents to the child's admission to a residential treatment or habilitation program;

(2) whether the admission is in the child's best interests; and

(3) whether the admission is appropriate for the child and is consistent with the least restrictive means principle.

H. If a guardian ad litem determines that the child's legal custodian understands and consents to the child's admission and that the admission is in the child's best interests, is appropriate for the child and is consistent with the least restrictive means principle, the guardian ad litem shall so certify on a form designated by the supreme court. The form, when completed by the guardian ad litem, shall be filed in the child's patient record kept by the residential treatment or habilitation program, and a copy shall be forwarded to the court or special commissioner within seven days of the child's admission. The guardian ad litem's statement shall not identify the child by name.

I. Upon reaching the age of fourteen, a child who was admitted to a residential treatment or habilitation program pursuant to this section may petition the district court for the records of the district court regarding all matters pertinent to the child's admission to a residential treatment or habilitation program. The district court, upon receipt of the petition and upon a determination that the petitioner is in fact a child who was admitted to a residential treatment or habilitation program, shall provide all court records regarding the admission to the petitioner, including all copies in the court's possession, unless there is a showing that release of records would cause substantial harm to the child. Upon reaching the age of eighteen, a person who was admitted to a residential or treatment or habilitation program as a child may petition the district court for such records, and the district court shall provide all court records regarding the admission to the petitioner, including all copies in the court's possession.

J. A legal custodian who consents to admission of a child to a residential treatment or habilitation program has the right to request the child's immediate discharge from the residential treatment or habilitation program, subject to the provisions of this section. If a child's legal custodian informs the director, a physician or other member of the residential treatment or habilitation program staff that the legal custodian desires the child to be discharged from the program, the director, physician or other staff shall provide for the child's immediate discharge and remit the child to the legal custodian's care. The residential treatment or habilitation program shall also notify the child's guardian ad litem. A child whose legal custodian requests the child's immediate discharge shall be discharged, except when the director of the residential treatment or habilitation program, a physician or a licensed psychologist determines that the child requires continued treatment and that the child meets the criteria for involuntary residential treatment. In that event, the director, physician or licensed psychologist shall, on the first business day following the child's legal custodian's request for release of the child from the program, request that the children's court attorney initiate involuntary residential treatment proceedings. The children's court attorney may petition the court for such proceedings. The child has a right to a hearing regarding the child's continued treatment within seven days of the request for release.

K. A residential treatment or habilitation program shall review the admission of a child at the end of a sixty-day period after the date of initial admission, and the child's physician or licensed psychologist shall review the admission to determine whether it is in the best interests of the child to continue the admission. If the child's physician or licensed psychologist concludes that continuation of the residential treatment or habilitation program is in the child's best interests, the child's clinician shall so state in a form to be filed in the child's patient records. The residential treatment or habilitation program shall notify the guardian ad litem for the child at least seven days prior to the date that the sixty-day period is to end or, if necessary, request a guardian ad litem pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act. The guardian ad litem shall then personally meet with the child, the child's legal custodian and the child's clinician and ensure that the child's legal custodian understands and consents to the child's continued admission to the residential treatment or habilitation program. If the guardian ad litem determines that the child's legal custodian understands and consents to the child's continued admission to the residential treatment or habilitation program, that the continued admission is in the child's best interest, that the placement continues to be appropriate for the child and consistent with the least restrictive means principle and that the clinician has recommended the child's continued stay in the program, the guardian ad litem shall

so certify on a form designated by the supreme court. The disposition of these forms shall be as set forth in this section, with one copy going in the child's patient record and the other being sent to the district court in a manner that preserves the child's anonymity. This procedure shall take place every sixty days following the child's last admission or a guardian ad litem's certification, whichever occurs first.

L. When a guardian ad litem determines that the child's legal custodian does not understand or consent to the child's admission to a residential treatment or habilitation program, that the admission is not in the child's best interests, that the placement is inappropriate for the child or is inconsistent with the least restrictive means principle or that the child's clinician has not recommended a continued stay by the child in the residential treatment or habilitation program, the child shall be released or involuntary placement procedures shall be initiated.

M. If the child's legal custodian is unavailable to take custody of the child and immediate discharge of the child would endanger the child, the residential treatment or habilitation program may detain the child until a safe and orderly discharge is possible. If the child's legal custodian refuses to take physical custody of the child, the residential treatment or habilitation program shall refer the case to the department for an abuse and neglect or family in need of court-ordered services investigation. The department may take the child into protective custody pursuant to the provisions of the Abuse and Neglect Act [Chapter 32A, Article 4 NMSA 1978] or the Family in Need of Court-Ordered Services Act [Chapter 32A, Article 3B NMSA 1978].

History: Laws 2007, ch. 162, § 20; 2008, ch. 75, § 5.

ANNOTATIONS

Compiler's note. — The Family in Need of Court-Ordered Services Act cited in Subsection M, was repealed by Laws 2005, ch. 189, § 77. For current law, *see* the Family in Need of Services Act, 32A-3A-1 NMSA 1978.

The 2008 amendment, effective May 14, 2008, changed "drastic" to "restrictive" in Paragraph (3) of Subsections G and H.

32A-6A-21. Voluntary residential treatment or habilitation for children fourteen years of age or older.

A. A child fourteen years of age or older shall not receive treatment for mental disorders or habilitation for developmental disabilities on a voluntary residential basis, except as provided in this section.

B. An admission of a child fourteen years of age or older to a residential treatment or habilitation program is voluntary when it is medically necessary and consented to by the child and the child's legal custodian as set forth in this section, provided that the admission does not exceed sixty days, subject to the requirements of this section.

C. To have a child voluntarily admitted to a residential treatment or habilitation program, the child and the child's legal custodian shall knowingly and voluntarily execute, prior to admission, a child's voluntary consent to admission document. The document shall include a clear statement of the child's right to voluntarily consent or to request an immediate discharge from the residential treatment or habilitation program at any time; and the child's rights when the child requests a discharge and the child's physician, licensed psychologist or the director of the residential treatment or habilitation program determines the child needs continued treatment. The residential treatment or habilitation program shall ensure that each statement is clearly explained in the child's and legal custodian's primary language, if that is their language of preference, and in a manner appropriate to the child's and legal custodian's developmental abilities, and each statement shall be initialed by the child and the child's legal custodian.

D. A child who is admitted on a voluntary basis has a right to an attorney. Prior to admission, the residential treatment or habilitation program shall inform the child's legal custodian of the child's right to an independent attorney within seventy-two hours. If the child's legal custodian is unable to obtain an independent attorney, the legal custodian may petition the court to appoint an attorney for the child. If the child's legal custodian obtains an independent attorney for the child, the legal custodian shall notify the residential treatment or habilitation program of that attorney's name within seventy-two hours of the child's voluntary admission.

E. The child's executed voluntary consent to admission document shall be filed in the child's treatment record within twenty-four hours of the time of admission.

F. Upon the filing of the child's voluntary consent to admission document in the child's treatment record, the director of the residential treatment or habilitation program or the director's designee shall, on the next business day following the child's admission, notify the district court or the special commissioner of the admission, giving the child's name, date of birth and the date and place of admission. Upon receipt of notice of a child's voluntary admission to a residential treatment or habilitation program, the court or special commissioner shall establish a sequestered court file.

G. If within seventy-two hours of the child's voluntary admission the child has not met with an independent attorney and the child's legal custodian has not notified the residential treatment or habilitation program of the name of the child's independent attorney, the residential treatment or habilitation program shall during the next business day petition the court to appoint an attorney. When the court receives the petition, the court shall appoint an attorney.

H. If within seventy-two hours of the child's voluntary admission the child has met with an independent attorney or the child's legal custodian has notified the residential treatment or habilitation program of the name

of the child's independent attorney, the residential treatment or habilitation program shall during the next business day notify the court or the special commissioner of the name of the child's independent attorney.

I. Within seven days of the admission, an attorney representing the child pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act shall meet with the child. At the meeting with the child, the attorney shall explain to the child the following:

(1) the child's right to an attorney;

(2) the child's right to terminate the child's voluntary admission and the procedures to effect termination;

(3) the effect of terminating the child's voluntary admission and options of the clinician and other interested parties to petition for an involuntary admission; and

(4) the child's rights under the provisions of the Children's Mental Health and Developmental Disabilities Act, including the right to:

(a) legal representation;

(b) a presumption of competence;

(c) receive daily visitors of the child's choice;

(d) receive and send uncensored mail;

(e) have access to telephones;

(f) follow or abstain from the practice of religion;

(g) a humane and safe environment;

(h) physical exercise and outdoor exercise;

(i) a nourishing, well-balanced, varied and appetizing diet;

(j) medical treatment;

(k) educational services;

(l) freedom from unnecessary or excessive medication;

(m) individualized treatment and habilitation; and

(n) participation in the development of the individualized treatment plan and access to that plan on request.

J. If the attorney determines that the child understands the child's rights and that the child voluntarily and knowingly desires to remain as a patient in a residential treatment or habilitation program, the attorney shall so certify on a form designated by the supreme court. The form, when completed by the attorney, shall be filed in the child's patient record at the residential treatment or habilitation program, and a copy shall be forwarded to the court or special commissioner within seven days of the child's admission. The attorney's statement shall not identify the child by name.

K. Upon reaching the age of fourteen, a child who was a voluntary admittee to a residential treatment or habilitation program may petition the district court for the records of the court regarding all matters pertinent to the child's voluntary admission to a residential treatment or habilitation program. The court, upon receipt of the petition and upon a determination that the petitioner was in fact the child who was a voluntary admittee to a residential treatment or habilitation program, shall give all court records regarding the admission to the petitioner, including all copies in the court's possession unless there is a showing that provision of records would cause substantial harm to the child. A person who was admitted to a residential or treatment or habilitation program as a child, upon reaching the age of eighteen, may petition the district court for such records and the district court shall provide all court records regarding the admission to the petitioner, including all copies in the court's possession.

L. Any child voluntarily admitted to a residential treatment or habilitation program has the right to an immediate discharge from the residential treatment or habilitation program upon the child's request, except as provided in this section. If a child informs the director, clinician or other member of the residential treatment or habilitation program staff that the child desires to be discharged from the voluntary program, the director, clinician or other staff member shall provide for the child's immediate discharge. The residential treatment or habilitation program shall not require that the child's request be in writing. Upon the request, the residential treatment or habilitation program shall notify the child's legal custodian to take custody of the child and remit the child to the legal custodian's care. The residential treatment or habilitation program shall also notify the child's attorney. If the child's legal custodian is unavailable to take custody of the child and immediate discharge of the child would endanger the child, the residential treatment or habilitation program may detain the child until a safe and orderly discharge is possible. If the child's legal custodian refuses to take physical custody of the child, the residential treatment or habilitation program shall refer the case to the department for an abuse and neglect or family in need of court-ordered services investigation. The department may take the child into protective custody pursuant to the provisions of the Abuse and Neglect Act [Chapter 32A, Article 4 NMSA 1978] or the Family in Need of Court-Ordered Services Act [Chapter 32A, Article 3B NMSA 1978]. A child requesting immediate discharge shall be discharged, except in those situations when the director of the residential treatment or habilitation program, a physician or a licensed psychologist determines that the child requires continued treatment and that the child meets the criteria for involuntary residential treatment or habilitation services as otherwise provided under the Children's Mental Health and Developmental Disabilities Act. In that event, the director, physician or licensed psychologist, after making the determination, shall, on the first business day following the child's request for release from the voluntary program, request that the child's court attorney initiate involuntary placement proceedings. The child's court attorney may petition for such a placement. The child has a right to a hearing on the child's continued treatment within five days of the child's request for release.

M. A child who is voluntarily admitted to a residential treatment or habilitation program shall have the child's voluntary admission reviewed at the end of a sixty-day period from the date of the child's initial admission to the program. The review shall be accomplished by having the child's physician or licensed psychologist review the child's treatment and determine whether it would be in the best interests of the child to continue the voluntary admission. If the child's physician or licensed psychologist concludes that continuation of treatment is in the child's best interests, the child's clinician shall so state in a form to be filed in the child's patient record. The residential treatment or habilitation program shall notify the child's attorney at least seven days prior to the date that the sixty-day period is to end or, if necessary, request an attorney pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act. The attorney shall then personally meet with the child and ensure that the child understands the child's rights as set forth in this section, that the child understands the method for voluntary termination of the child's admission and that the child knowingly and voluntarily consents to the child's continued treatment. If the attorney determines that the child understands these rights and that the child voluntarily and knowingly desires to remain in the residential treatment or habilitation program and that the clinician has recommended the continued stay in the program, the attorney shall so certify on a form designated by the supreme court. The disposition of these forms shall

be as set forth in this section, with one copy going in the child's patient record and the other being sent to the district court in a manner that preserves the child's anonymity. This procedure shall take place every sixty days from the last admission or attorney's certification, whichever comes first.

N. If the attorney determines that the child does not voluntarily desire to remain in the program or if the child's clinician has not recommended continued stay by the child in the residential treatment or habilitation program, the child shall be released pursuant to the involuntary placement procedures set forth in this section and the Children's Mental Health and Developmental Disabilities Act shall be followed.

History: Laws 2007, ch. 162, § 21.

ANNOTATIONS

Cross references. — For provisions of the 1995 Children's Mental Health and Developmental Disabilities Act, relating to voluntary treatment, *see* the 2006 NMSA 1978 (32A-6-12) on *NMOneSource.com.*

Compiler's note. — The Family in Need of Court-Ordered Services Act cited in Subsection L, was repealed by Laws 2005, ch. 189, § 77. For current law, *see* the Family in Need of Services Act, 32A-3A-1 NMSA 1978.

Effective dates. — Laws 2007, ch. 162 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 15, 2007, 90 days after the adjournment of the legislature.

In entertaining petition for pro bono appointment of attorney to represent a child, the district court was exercising jurisdiction conferred on district courts by the Children's Mental Health and Developmental Disabilities Act. *In re Kleinsmith*, 2005-NMCA-136, 138 N.M. 601, 124 P.3d 579, cert. denied, 546 U.S. 1034, 126 S. Ct. 758, 163 L. Ed. 2d 574.

Absence of statement required by Subsection J of this section would have indicated to the district court that the appointed attorney had not complied with the district court's order, and in such a case, it was not necessary to support the order to show cause with a sworn affidavit. *In re Kleinsmith*, 2005-NMCA-136, 138 N.M. 601, 124 P.3d 579, cert. denied, 546 U.S. 1034, 126 S. Ct. 758, 163 L. Ed. 2d 574.

Telephone interview permissible. — Although a face-to-face meeting is preferred, an appointed attorney could have interviewed the child by telephone to carry out his responsibilities under Subsection I of this section. *In re Kleinsmith*, 2005-NMCA-136, 138 N.M. 601, 124 P.3d 579, cert. denied, 546 U.S. 1034, 126 S. Ct. 758, 163 L. Ed. 2d 574.

32A-6A-22. Involuntary residential treatment.

A. A child may not receive treatment for mental disorders or habilitation for developmental disabilities on an involuntary residential basis except as provided in this section.

B. A child afforded rights under the Children's Mental Health and Developmental Disabilities Act shall be advised of those rights at that child's first appearance before the court on a petition under that act.

C. A child has the right to be placed in a residential treatment or habilitation program only when the placement is medically necessary.

D. A person who believes that a child, as a result of a mental disorder or developmental disability, is in need of residential mental health or developmental disabilities services may request that a children's court attorney file a petition with the court for the child's involuntary placement. The petition shall include a detailed description of the symptoms or behaviors of the child that support the allegations in the petition, a list of prospective witnesses for involuntary placement and a summary of matters to which they will testify. The petition should also contain a discussion of the alternatives to residential care that have been considered and the reasons for rejecting the alternatives. A copy of the petition shall be served upon the child, the child's legal custodian and the child's attorney or guardian ad litem.

E. The court shall, upon receiving the petition, appoint counsel for the child unless the child has retained an attorney or an attorney or guardian ad litem has been appointed pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act. The attorney or guardian ad litem shall represent the child at all stages of the proceedings.

F. If, after interviewing the child, the child's attorney or guardian ad litem determines that the child understands the child's rights and desires to waive the child's presence at the hearing on the issue of involuntary placement, the attorney or guardian ad litem shall submit a verified written statement to the court explaining the attorney's or guardian ad litem's understanding of the child's intent. If the court is satisfied that the child has voluntarily and knowingly waived the child's right to be present at the hearing, the child may be involuntarily placed in a residential treatment or habilitation program at a hearing at which the child is not present. By waiving the right to be present at the involuntary placement hearing, the child waives no other rights.

G. An involuntary placement hearing shall be held within seven days of the emergency admission of the child to a residential treatment or habilitation program under this section. An involuntary placement hearing shall be held within five days from a child's declaration that the child desires to terminate the child's voluntary admission to a residential treatment or habilitation program if the child's clinician has assessed and documented that involuntary placement is necessary.

H. At the involuntary placement hearing, the child shall:

(1) at all times be represented by counsel;

(2) have the right to present evidence, including the testimony of a mental health and developmental disabilities professional of the child's own choosing;

(3) have the right to cross-examine witnesses;

(4) have the right to a complete record of the proceedings; and

(5) have the right to an expeditious appeal of an adverse ruling.

I. The legal custodian of a child involved in an involuntary placement hearing shall have automatic standing as witnesses and shall be allowed to testify by telephone or through a written affidavit if circumstances make personal testimony too burdensome.

J. The court shall include in its findings either a statement of the child's legal custodian's opinion about whether the child should be involuntarily placed in a residential treatment or habilitation program, a statement detailing the efforts made to ascertain the legal custodian's opinion or a statement of why it was not in the child's best interests to have the legal guardian involved.

K. The court shall make an order involuntarily placing the child in a residential treatment or habilitation program upon a showing by clear and convincing evidence that:

(1) as a result of mental disorder or developmental disability the child needs the treatment or habilitation services proposed;

(2) as a result of mental disorder or developmental disability the child is likely to benefit from the treatment or habilitation services proposed;

(3) the proposed involuntary placement is consistent with the treatment or habilitation needs of the child; and

(4) the proposed involuntary placement is consistent with the least restrictive means principle.

L. If the court determines that the child does not meet the criteria for involuntary placement set forth in this section, it may order the child to undergo nonresidential treatment or habilitation as may be appropriate and necessary or it may order no treatment. If the court determines that the child should not be involuntarily placed in a residential treatment or habilitation program and if the child's legal custodian refuses to take custody of the child, the court shall refer the case to the department for an abuse and neglect investigation. The department may take the child into custody pursuant to the provisions of the Abuse and Neglect Act [Chapter 32A, Article 4 NMSA 1978] or the Family in Need of Court-Ordered Services Act [Chapter 32A, Article 3B NMSA 1978].

M. A child receiving involuntary residential treatment or habilitation services for a mental disorder or developmental disability under this section shall have a right to periodic review of the child's involuntary placement at the end of every involuntary placement period. An involuntary placement period shall not exceed sixty days. At the expiration of an involuntary placement period, the child may continue in residential care only after a new involuntary placement hearing and entry of a new order of involuntary placement for one involuntary placement period. Nothing set forth in the Children's Mental Health and Developmental Disabilities Act prohibits a child, who has been involuntarily placed and thereafter discharged and released, from subsequently voluntarily consenting to admission under the provisions of that act.

N. If the person seeking the involuntary placement of a child to a residential treatment or habilitation program believes that the child is likely to cause serious bodily harm to self or to others during the period that would be required to hold an involuntary placement hearing as provided in this section, the child may be admitted to residential care on an emergency basis. If the child is admitted on an emergency basis, appointment of counsel and other procedures shall then take place as provided elsewhere in this section.

History: Laws 2007, ch. 162, § 22

ANNOTATIONS

Cross references. — For provisions of the 1995 Children's Mental Health and Developmental Disabilities Act, relating to involuntary, *see* the 2006 NMSA 1978 (32A-6-13) on *NMOneSource.com.*

Compiler's note. — The Family in Need of Court-Ordered Services Act cited in Subsection L, was repealed by Laws 2005, ch. 189, § 77. For current law, *see* the Family in Need of Services Act, 32A-3A-1 NMSA 1978.

Effective dates. — Laws 2007, ch. 162 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 15, 2007, 90 days after the adjournment of the legislature.

Decisions under prior law. — In light of the similarity of the provisions, annotations decided under former Section 43-1-16.1 NMSA 1978 have been included in the annotations to this section.

Children's court is presumed to know what evidence is necessary to find child "committable," in order that the court may be able to make the necessary finding that the child is not committable. *State v. Doe*, 1982-NMCA-128, 98 N.M. 567, 650 P.2d 851, cert. denied, 98 N.M. 590, 651 P.2d 636.

Court may find child "not committable". — Where, no matter how the defendant's problems might be classified, there is no available program or facility that can adequately treat him, the court can find that he is not "committable." *State v. Doe*, 1982-NMCA-128, 98 N.M. 567, 650 P.2d 851, cert. denied, 98 N.M. 590, 651 P.2d 636.

Private attorney may petition a court for involuntary commitment of a minor to a mental health facility. 1988 Op. Att'y Gen. No. 88-02.

Law reviews. — For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M.L. Rev. 279 (1980).

For article, "Child Welfare Under the Indian Child Welfare Act of 1978: A New Mexico Focus," see 10 N.M.L. Rev. 413 (1980).

32A-6A-24. Disclosure of information.

A. Except as otherwise provided in the Children's Mental Health and Developmental Disabilities Act, a person shall not, without the authorization of the child, disclose or transmit any confidential information from which a person well-acquainted with the child might recognize the child as the described person or any code, number or other means that could be used to match the child with confidential information regarding the child.

B. When the child is under fourteen years of age, the child's legal custodian is authorized to consent to disclosure on behalf of the child. Information shall also be disclosed to a court-appointed guardian ad litem without consent of the child or the child's legal custodian.

C. A child fourteen years of age or older with capacity to consent to disclosure of confidential information shall have the right to consent to disclosure of mental health and habilitation records. A legal custodian who is authorized to make health care decisions for a child has the same rights as the child to request, receive, examine, copy and consent to the disclosure of medical or other health care information when evidence exists that such a child whose consent to disclosure of confidential information is sought does not have capacity to give or withhold valid consent and does not have a treatment guardian appointed by a court. If the legal custodian is not authorized to make decisions for a child under the Children's Mental Health and Developmental Disabilities Act, the person seeking authorization shall petition the court for the appointment of a treatment guardian to make a decision for such a child.

D. Authorization from the child or legal custodian shall not be required for the disclosure or transmission of confidential information when the disclosure or transmission:

(1) is necessary for treatment of the child and is made in response to a request from a clinician;

(2) is necessary to protect against a clear and substantial risk of imminent serious physical injury or death inflicted by the child on self or another;

(3) is determined by a clinician not to cause substantial harm to the child and a summary of the child's assessment, treatment plan, progress, discharge plan and other information essential to the child's treatment is made to a child's legal custodian or guardian ad litem;

(4) is to the primary caregiver of the child and the information disclosed was necessary for the continuity of the child's treatment in the judgment of the treating clinician who discloses the information;

(5) is to an insurer contractually obligated to pay part or all of the expenses relating to the treatment of the child at the residential facility. The information disclosed shall be limited to data identifying the child, facility and treating or supervising physician and the dates and duration of the residential treatment. It shall not be a defense to an insurer's obligation to pay that the information relating to the residential treatment of the child, apart from information disclosed pursuant to this section, has not been disclosed to the insurer;

(6) is to a protection and advocacy representative pursuant to the federal Developmental Disabilities Assistance and Bill of Rights Act and the federal Protection and Advocacy for Individuals with Mental Illness Act;

(7) is pursuant to a court order issued for good cause shown after notice to the child and the child's legal custodian and opportunity to be heard is given. Before issuing an order requiring disclosure, the court shall find that:

(a) other ways of obtaining the information are not available or would not be effective; and

(b) the need for the disclosure outweighs the potential injury to the child, the clinician-child relationship and treatment services; or

(8) is, for all confidential information in existence on and after July 1, 2024, to a governmental agency, its agent or a state educational institution, a duly organized state or county association of licensed physicians or dentists or a licensed health facility or staff committees of such a facility for the purpose of research, subject to the provisions of Section 14-6-1 NMSA 1978 and subject to the review of an institutional review board in compliance with the federal Health Insurance Portability and Accountability Act of 1996 or any succeeding legislation and any federal regulations governing institutional review boards.

E. A disclosure ordered by the court shall be limited to the information that is essential to carry out the purpose of the disclosure. Disclosure shall be limited to those persons whose need for the information forms the basis for the order. An order by the court shall include such other measures as are necessary to limit disclosure for the protection of the child, including sealing from public scrutiny the record of a proceeding for which disclosure of a child's record has been ordered.

F. An authorization given for the transmission or disclosure of confidential information shall not be effective unless it:

(1) is in writing and signed; and

(2) contains a statement of the child's right to examine and copy the information to be disclosed, the name or title of the proposed recipient of the information and a description of the use that may be made of the information.

G. The child has a right of access to confidential information about the child and has the right to make copies of information about the child and submit clarifying or correcting statements and other documentation of reasonable length for inclusion with the confidential information. The statements and other documentation shall be kept with the relevant confidential information, shall accompany it in the event of disclosure and shall be governed by the provisions of this section to the extent the statements or other documentation contain confidential information. Nothing in this subsection shall prohibit the denial of access to the records when a physician or other mental health or developmental disabilities professional believes and notes in the child's medical records that the disclosure would not be in the best interests of the child. In all cases, the child has the right to petition the court for an order granting access.

H. Information concerning a child disclosed under this section shall not be released to any other person, agency or governmental entity or placed in files or computerized data banks accessible to any persons not otherwise authorized to obtain information under this section. Notwithstanding the confidentiality provisions of the Delinquency Act [Chapter 32A, Article 2 NMSA 1978] and the Abuse and Neglect Act Chapter [32A, Article 4 NMSA 1978], information disclosed under this section shall not be re-released without the express consent of the child or legal custodian authorized under the Children's Mental Health and Developmental Disabilities Act to give consent and any other consent necessary for redisclosure in conformance with state and federal law, including consent that may be required from the professional or the facility that created the document.

I. Nothing in the Children's Mental Health and Developmental Disabilities Act shall limit the confidentiality rights afforded by federal statute or regulation.

J. The department shall promulgate rules for implementing disclosure of records pursuant to this section and in compliance with state and federal law and the Children's Court Rules.

History: Laws 2007, ch. 162, § 24; 2008, ch. 75, § 6; 2024, ch. 31, § 1.

ANNOTATIONS

Cross references. — For the federal Developmental Disabilities Assistance and Bill of Rights Act, *see* 42 U.S.C. § 6001.

For the federal Protection and Advocacy for Mentally Ill Individuals Act of 1991, *see* 42 U.S.C. § 10801.

For provisions of the 1995 Children's Mental Health and Developmental Disabilities Act, relating to disclosure of information, *see* the 2006 NMSA 1978 (32A-6-15) on *NMOneSource.com.*

The 2024 amendment, effective July 1, 2024, removed a certain restriction on the release of confidential information related to children under fourteen years of age, and provided for additional disclosure of confidential information for certain purposes; and in Subsection D, after "child or legal custodian" deleted "for a child less than fourteen years of age", and added Paragraph D(8).

The 2008 amendment, effective May 14, 2008, in Subsection D, provided that authorization from the legal custodian for a child less than fourteen year of age shall not be required if the listed conditions apply.

32A-21-3. Emancipated minors; description.

An emancipated minor is any person sixteen years of age or older who:

A. has entered into a valid marriage, whether or not the marriage was terminated by dissolution;

B. is on active duty with any of the armed forces of the United States of America; or

C. has received a declaration of emancipation pursuant to the Emancipation of Minors Act.

History: Laws 1995, ch. 206, § 49.

32A-21-5. Over the age of majority; purposes.

An emancipated minor shall be considered as being over the age of majority for one or more of the following purposes:

A. consenting to medical, dental or psychiatric care without parental consent, knowledge or liability;

B. his capacity to enter into a binding contract;

C. his capacity to sue and be sued in his own name;

D. his right to support by his parents;

E. the rights of his parents to his earnings and to control him;

F. establishing his own residence;

G. buying or selling real property;

H. ending all vicarious liability of the minor's parents, guardian or custodian for the minor's torts; provided that nothing in this section shall affect any liability of a parent, guardian, custodian, spouse or employer of a minor imposed by the Motor Vehicle Code [Chapter 66, Articles 1 through 8 NMSA 1978] or any vicarious liability that arises from an agency relationship; or

I. enrolling in any school or college.

History: Laws 1995, ch. 206, § 51.

ANNOTATIONS

Cross references. — For consent to medical care by emancipated minors, *see* 24-10-1 NMSA 1978.

Partial emancipation. — The district court may emancipate a minor for some, rather than all of the enumerated purposes, and reserve the minor's rights with respect to other purposes, including the right to financial support from a parent. *Diamond v. Diamond*, 2012-NMSC-022, 283 P.3d 260, *rev'g* 2011-NMCA-002, 149 N.M. 133, 245 P.3d 578.

Emancipation reserving right to support from parents. — Where the district court issued a declaration of emancipation declaring the minor "an emancipated minor in all respects, except that [the minor] shall retain the right to support" from the minor's parent; and the minor petitioned the district court to order the minor's parent to pay retroactive and prospective child support to the minor, the district court's reservation of the minor's right to seek child support and the award of child support was consistent with the Emancipation of Minors Act. *Diamond v. Diamond*, 2012-NMSC-022, 283 P.3d 260, *rev'g* 2011-NMCA-002, 149 N.M. 133, 245 P.3d 578.

List of benefits and consequences of emancipation. — Section 32A-21-15 NMSA 1978 lists the types of benefits and consequences of emancipation under various circumstances, but does not authorize a partial emancipation. *Diamond v. Diamond*, 2011-NMCA-002, 149 N.M. 133, 245 P.3d 578, *rev'd*, 2012-NMSC-022, 283 P.3d 260.

Post-emancipation child support. — New Mexico law does not permit a minor emancipated pursuant to the Emancipation of Minors Act to collect child support payments for the period after emancipation and continuing until the emancipated minor reaches the age of eighteen. *Diamond v. Diamond*, 2011-NMCA-002, 149 N.M. 133, 245 P.3d 578, *rev'd*, 2012-NMSC-022, 283 P.3d 260.

APPENDIX B[57]
HIPAA PRIVACY RULE AND CONFIDENTIALITY IMPLICATIONS FOR MINORS

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) has overarching importance to parents.

What is the HIPAA Privacy Rule?

The HIPAA Privacy Rule[58] is a federal law that protects the privacy of individually identifiable patient health information held by "covered entities."[59] As a general rule, HIPAA privacy protections generally allow individuals to access their own health information and to control the disclosure of that information in some circumstances. The Rule applies to the health information of minors as well as adults.[60]

Who is required to comply with the HIPAA Privacy Rule?

The HIPAA Privacy Rule protects the privacy of individually identifiable information held by covered entities. HIPAA defines "covered entity" as health plans, health care clearinghouses, and health care providers who transmit health information in electronic format related to certain types of transactions.[61]

Health care providers who "transmit health information in electronic form" are "covered entities" and must therefore comply with HIPAA.[62] "Health care providers" include individual providers such as physicians, nurses, clinical social workers, and other medical and mental health practitioners, as well as hospitals, clinics, and other organizations.[63] At times, the "business associates" of "covered entities" may be obligated to comply with HIPAA as well.[64]

What information does the HIPAA Privacy Rule Protect?

The HIPAA Privacy Rule controls the disclosure of patients' "protected health information" (PHI).[65] The Act defines PHI broadly and includes individually identifiable information about the health, provision of health care, or payment for health care of an individual, created or received by a health care provider, health plan, employer, or health care clearinghouse in any form, including oral communications as well as written or electronically transmitted information.[66] PHI includes health and mental health information but special provisions apply to "psychotherapy notes."[67] HIPAA does not limit the disclosure of health information that is not individually identifiable, generally refereed to as "de-identified information."[68]

[57] Appendix B copied from Appendix H of the National Center for Youth Law's *Minor Consent and Confidentiality A Compendium of State and Federal Laws, August 2024,* available at: https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024.pdf.
[58] 45 C.F.R. Part 160 and Part 164, Subparts A and E.
[59] 45 C.F.R. § 160.102.
[60] English A, Ford C. The HIPAA Privacy Rule and adolescents: Legal and ethical questions multiply. Persp on Sexual Reprod Health 2004; 36(2):80-86. Available at: https://www.guttmacher.org/journals/psrh/2004/hipaa-privacy-rule-and-adolescents-legal-questions-and-clinical-challenges.
[61] 45 C.F.R. § 160.102.
[62] 45 C.F.R. § 164.104.
[63] 45 C.F.R. § 160.103.
[64] 45 C.F.R. § 160.103.
[65] 45 C.F.R. § 164.502(a).
[66] 45 C.F.R. § 160.103.
[67] 45 C.F.R. § 164.501.
[68] 45 C.F.R. §§ 164.502(a), 164.514.

When are covered entities allowed or required to disclose PHI under the HIPAA Privacy Rule?

The HIPAA Privacy Rule generally requires written authorization before a covered entity may share PHI.[69] The regulations require that a release include specific elements and notices to be considered compliant.[70] That said, the HIPAA Privacy Rule contains exceptions that either allow or require disclosure of PHI without a written authorization, provided certain requirements are satisfied.[71] These exceptions, among others, include disclosures:

- For treatment, payment, and health care operations[72]
- To avert a serious and imminent threat[73]
- For research purposes[74]
- To public health authorities as required by law[75]
- To report child abuse as required by law[76]
- To protect victims of domestic violence[77]

For purposes of the "treatment" exception, HIPAA defines treatment as: "the provision, coordination, or management of health care and related services by one or more health care providers; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another."

It is important to know who is legally authorized to sign a written authorization in situations in which one is legally required or when health care providers choose to obtain one even in situations covered by one of the exceptions.

Who is authorized to sign a release of information under the HIPAA Privacy Rule?

Adults and emancipated minors sign their own releases of information, unless they are under a legal disability. In most cases, the "personal representative" of an unemancipated minor must sign a release on the minor's behalf. HIPAA defines the personal representative of an unemancipated minor as a parent, guardian, or other person acting in loco parentis, who has authority to act on behalf of the unemancipated minor in making decisions related to health care.[78] An unemancipated minor has the authority to sign their own releases of information when they are considered by the Rule to be an "individual."

When does HIPAA treat minors as an "individual"?

The HIPAA Privacy Rule grants unemancipated minors the authority to act as an "individual," able to exercise rights on their own behalf, in three specific situations:

- the minor is legally authorized to consent for their care, the minor does so, and no other consent is required by law; or
- the minor lawfully may obtain care without the consent of a parent or person acting in place of the parent such as a legal guardian, and the minor, a court, or another person authorized by law for the care; or

[69] 45 C.F.R. §§ 164.502(a), 164.508.
[70] 45 C.F.R. § 164.508.
[71] 45 C.F.R. § 164.512.
[72] 45 C.F.R. §§ 164.502(a)(1)(ii), 164.506.
[73] 45 C.F.R. § 164.512(j)(i).
[74] 45 C.F.R. § 164.512(i).
[75] 45 C.F.R. § 164.512(b).
[76] 45 C.F.R. § 164.512(b)(1)(ii).
[77] 45 C.F.R. § 164.512(c).
[78] 45 C.F.R. 164.502(g)(3)(i).

- a parent, guardian, or person acting in place of a parent assents to an agreement of confidentiality between the minor and the health care provider.[79]

In these three situations, the minor is considered "the individual" and one consequence is that the minor's signature is required to release their PHI – unless they have agreed to have their parent, guardian, or person acting as a parent serve as their personal representative. A minor in these situations may also exercise other rights under the Privacy Rule.

Do parents/guardians always have access to minor's PHI under the HIPAA Privacy Rule?

Not always. Parents' access to their unemancipated minor child's information is limited in two situations.

First, parents/guardians' access may be limited when the minor has authority to act as an "individual" as defined by HIPAA.[80] When a minor has authority to act as an "individual," the HIPAA Privacy Rule adopts the following approach related to parent/guardian access:

- If, and to the extent, disclosure is permitted by an applicable state or other law (including a federal law), or applicable case law, a covered entity may disclose, or provide access to protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis, in accordance with HIPAA and the applicable law;
- If, and to the extent, disclosure is required by an applicable state or other law (including a federal law), or applicable case law, a covered entity may disclose, or provide access to protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis, in accordance with HIPAA and the applicable law;
- If, and to the extent, disclosure is prohibited (e.g. without the permission of the minor) by an applicable state or other law (including a federal law) or applicable case law, a covered entity may not disclose, or provide access to protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis, in accordance with the applicable law; and
- Where state and other law are silent, a covered entity may provide or deny access to a parent, guardian, or other person acting in loco parentis, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment.[81]

Second, where a parent or guardian otherwise has the authority to access a minor's records, even where permitted or required by a state or other applicable law, HIPAA offers a general exception authorizing health care providers to limit parent/guardian access when necessary to protect the minor's safety.[82] (See next question.)

In other words, except as described in the next question, state or other laws that explicitly permit, require, or prohibit disclosure of information to a parent or guardian are controlling.[83] If state or other laws are silent on the question of parents' access, a health care provider exercising professional judgment has discretion to determine whether or not to grant access.[84]

The relevant sources of state or other law that a health care provider must consider include all of the state and federal laws that contain confidentiality protections or disclosure requirements. In light of HIPAA's

[79] 45 C.F.R. § 164.502(g)(3)(i).
[80] 45 C.F.R. § 164.502(g)(3)(ii).
[81] 45 C.F.R. § 164.502(g)(3)(ii).
[82] 45 § C.F.R. 164.502 (g)(5).
[83] 45 C.F.R. § 164.502(g)(3)(ii)(A) and (B).
[84] 45 C.F.R. § 164.502(g)(3)(ii)(C).

deference to state or other laws on the issue of disclosure and access for a parent or guardian, understanding the state law approaches to these issues is critical.

When may a health care provider restrict parent or guardian access to an unemancipated minor's PHI for safety reasons under the HIPAA Privacy Rule?

In addition to those situations where a minor has authority to act as an "individual" for purposes of HIPAA and parental access to their health information is limited by state or other laws, there are two specific circumstances in which HIPAA gives a health care provider the authority to restrict a parent or guardian's access to a minor's PHI. The provider may restrict their access when:

- the provider has a reasonable belief that the minor has been or may be subject to domestic violence, abuse, or neglect by the parent; or
- giving the parent the right to access to the minor's medical information could endanger the minor, and the provider – in the exercise of professional judgment – decides that it is not in the best interest of the minor to provide the parent with access to the minor's medical information.[85]

These situations are sometimes referred to as the "safety" exception.

Does HIPAA offer minors any additional confidentiality protections when the minor has authority to act as an "individual" in relation to their PHI?

Yes. Additional provisions of the HIPAA Privacy Rule allow "individuals," including minors with authority to act as an individual, to request of both health care providers and insurers restrictions on the disclosure of their PHI and to request that communications regarding their PHI occur in a confidential manner.[86] Their right to request restrictions on disclosure of PHI related to billing and health insurance claims is discussed in Appendix F.

What protections does HIPAA provide for reproductive health care?

On April 26, 2024, HHS issued a new final rule, "HIPAA Privacy Rule to Support Reproductive Health Care Privacy." Compliance with the new rule is required by December 23, 2024.[87] The rule contains new definitions of "person," "public health," and "reproductive health care." The definition of "reproductive health care" for this purpose is "health care that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes. This definition shall not be construed to set forth a standard of care for or regulate what constitutes clinically appropriate reproductive health care."[88] The preamble to the new Rule contains an extensive non-exclusive list with examples of what is considered reproductive health care.[89] The new rule prohibits the use or disclosure of PHI in connection with any person seeking, obtaining, providing, or facilitating reproductive health care that was lawfully provided, when the purpose of the disclosure is: to investigate or to impose civil/criminal liability on any person; or to identify any person for merely seeking, obtaining, providing, or facilitating reproductive health care.[90]

What is the relationship between HIPAA, other federal laws, and state laws?

[85] 45 § C.F.R. 164.502 (g)(5).
[86] 45 C.F.R. §§ 164.502(h), 164.522(a)(1), and 164.522(b)(1)
[87] 89 Fed. Reg. 32976 (Apr. 26, 2024).
[88] 45 C.F.R. § 160.103.
[89] See 89 Fed. Reg. at 33005, 88 Fed. Reg. at 23527.
[90] American Medical Association, HIPAA Privacy Rule to Support Reproductive Health Care Privacy: AMA Drafted Summary of Regulatory Changes in Final Rule Published April 26, 2024; Compliance Required by December 23, 2024 https://www.ama-assn.org/system/files/summary-regulatory-changes-final-rule-reproductive-health-information.pdf.

The HIPAA Privacy Rule provides a "floor" of confidentiality protection. States cannot offer less protection but may require more. Thus, if state law offers more protection, providers should follow state law. Also, HIPAA provides that state laws and other applicable federal laws determine when parents/guardians have access to a minor's PHI when the minor is considered "the individual." Thus, if a state law or other law requires, prohibits, or permits parents' access, that law controls. In addition, HIPAA intersects in major ways with other federal laws such as the Part 2 substance use disorder confidentiality rules and the 21st Century Cures Act Information Blocking Rules.

Many federal laws affect the confidentiality of minors' health information when they consent for the care. These are discussed in detail in other Appendices and include: Title X (Appendix C), Part 2 (Appendix D), FERPA (Appendix E), billing and health insurance claims (Appendix F), and the 21st Century Cures Act (Appendix G).

APPENDIX C[91]
FEDERAL TITLE X FAMILY PLANNING PROGRAM AND MINORS'ACCESS TO FAMILY PLANNING SERVICES

What is the Title X Family Planning Program?

The Title X Family Planning Program is part of the federal Public Health Service Act. The Title X program is a grant funding program designed to provide access to family planning services—including contraceptive services, supplies, and information as well as related reproductive health and preventive health services beneficial to reproductive health—to all who want and need them, including adolescents.[92]1 It is "the only domestic federal program dedicated solely to family planning and related preventive health services" and is considered "a critical part of America's public health safety net, serving as a point of entry into care for nearly 195 million over the program's more than 50-year history."[93]

What Services are offered by Title X programs?

Programs that accept Title X funding must offer "a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, preconception health services)."

In addition, they may use Title X funding to offer "other reproductive health and related preventive health services that are considered beneficial to reproductive health such as HPV vaccination, provision of HIV pre-exposure prophylaxis (PrEP), breast and cervical cancer screening, and screening for obesity, smoking, drug and alcohol use, mental health, and intimate partner violence."[94]

Title X funded agencies must provide services in a way that is "client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with nationally recognized standards of care."[95]

Where are Title X services available?

The U.S. Department of Health and Human Services' (HHS) Office of Population Affairs (OPA) distributes Title X grants to "grantees" across the country who, in turn, distribute that funding to "sub-recipients" who support service sites. These service sites vary from clinics run by state and local health departments to community health clinics, hospitals, and school-based health centers. OPA offers an online "clinic locator" to find the service sites with Title X services.

What state and federal laws apply to Title X services for minors?

When providing Title X-funded care, health care providers must follow federal Title X statutes and regulations.[96] In addition, providers must follow other applicable state and federal law to the extent possible.

[91] Appendix C copied from Appendix I of the National Center for Youth Law's *Minor Consent and Confidentiality A Compendium of State and Federal Laws, August 2024,* available at: https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024.pdf.
[92] U.S. Department of Health and Human Services, Office of Population Affairs, *About Title X Service Grants*, available at https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants.
[93] U.S. Department of Health and Human Services, Office of Population Affairs, *The Title X Family Planning Program*,"available at: https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants.
[94] U.S. Department of Health and Human Services, Office of Population Affairs, *About Title X Service Grants*, available at https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants..
[95] 42 C.F.R. § 59.5(a)(3).
[96] See 42 U.S.C. § 300("The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural

Any differences between Title X requirements and other federal laws (e.g. HIPAA, Part 2, or the 21st Century Cures Act) would require specific analysis. As a general rule, courts have held that if a state law conflicts with the Title X statute or regulation, the Title X requirement preempts the state law if the state law would limit access or eligibility to the services provided through Title X.[97]

How does Title X address minor consent for family planning services?

The Title X statute states that Title X-funded services must be made available to adolescents, regardless of their age.[98] Title X regulation, 42 C.F.R. 59.10(b), provides that parent consent may not be required and notification of parents is not permitted for services funded through Title X, although projects must encourage family participation "to the extent practical."[99] Courts historically have prohibited implementation of any state law to the contrary, even if the state law required parental consent or notification for the same service.[100] In a recent case, Deanda v. Becerra, a parent claimed that implementation of Title X violated his rights under a Texas statute, which grants parents the right to consent to their child's medical care.[101] In 2024, the U.S. Court of Appeals for the Fifth Circuit found that it is possible to follow both Title X's implementation statute, 42 U.S.C.300(a), and Texas' law, and held that Title X programs thus must follow Texas' state consent law.[102] The Court declined to address whether 42 C.F.R. 59.10(b) itself preempts Texas' parent consent law. After this ruling, the U.S. Department of Health and Human Services' Office of Population Affairs (OPA) issued the following: "OPA will not be enforcing 42 C.F.R. § 59.10(b) in the State of Texas, nor will it enforce that regulation elsewhere in the fifth circuit to the extent it conflicts with state law. OPA will continue to enforce § 59.10(b) throughout the rest of the country. Title X projects in states in the Fifth Circuit other than Texas may wish to consult with their own counsel regarding their states' requirements with respect to confidentiality."[103] States in the Fifth Circuit include: Louisiana, Mississippi, and Texas.

How does Title X address confidentiality of minors' health care information?

The Title X regulations require Title X funded clinics to keep confidential "all information as to personal facts and circumstances obtained by the project staff" about patients.[104] The regulations prohibit the clinics from releasing this information unless (1) the clinic has written authorization for the release from the patient

family planning methods, infertility services, and services for adolescents). To the extent practical, entities which receive grants or contracts under this subsection shall encourage familiy1 participation in projects assisted under this subsection."); 42 C.F.R. § 59.1.

[97] See Planned Parenthood Federation v. Heckler, 712 F. 2d 650, 663-664 (D.C. Cir. 1983) ("[U]nder the Supremacy Clause of the Constitution states are not permitted to establish eligibility standards for federal assistance programs that conflict with the existing federal statutory or regulatory scheme."); *Planned Parenthood Assoc. of Utah v. Matheson*, 582 F. Supp. 1001, 1006 (D. Utah 1983); see also *County of St. Charles v. Missouri Family Health Counc*il, 107 F.3d 682 (8th Cir. 1997); *Does 1-4 v. Utah Dept. of Health*, 776 F.2d 253 (10th Cir. 1985); *Doe v. Pickett*, 480 F. Supp. 1218, 1220-1221 (D.W.Va. 1979); but see *Deanda vs. Becerra*, 645 F. Supp. 3d 600 (Dec. 8, 2022), 2022 WL 17843038 (N.D. Texas, Amarillo Div., Dec. 20, 2022), 96 F.4th 750, 768 (5th Cir. 2024).

[98] See 42 U.S.C. § 300(a).

[99] 42 C.F.R. § 59.10(b).

[100] *County of St. Charles v. Missouri Family Health Council*, 107 F.3d 682 (8th Cir. 1997), reh. den. 1997 U.S. App. LEXIS 6564, cert. den. 522 U.S. 859 (1997); see *Does 1-4 v. Utah Dept. of Health*, 776 F.2d 253 (10th Cir. 1985); *Planned Parenthood Assoc. of Utah v. Matheson*, 582 F. Supp. 1001, 1006 (D. Utah 1983); *State of N.Y v. Heckler*, 719 F.2d 1191 (2nd Cir. 1983); *Doe v. Pickett*, 480 F. Supp. 1218, 1220-1221 (D.W. Va. 1979).

[101] Texas Family Code § 151.001(a)(6)("A parent of a child has the following rights and duties: the right to consent to the child's marriage, enlistment in the armed forces of the United States, medical and dental care, and psychiatric, psychological, and surgical treatment").

[102] *Deanda v. Becerra*, 96 F.4th 750, 768 (5th Cir. 2024).

[103] OPA Program Policy Notice: 2024-01—Clarification Regarding Confidential Services to Adolescents under the Title X Program, March 22, 2024, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/programpolicy-notices/opa-program-policy-notice-2024-01-clarification-regarding-confidential-services-to-adolescents-under-thetitle-x-program.

[104] 42 C.F.R. § 59.10(a).

(including a minor patient), (2) the release is necessary to provide services to the patient, or (3) as required by law. The regulations also require that clinics implement "appropriate safeguards for confidentiality."[105]

Insurance and Billing

A Title X clinic is allowed to disclose information for purposes of collecting charges but must make "reasonable efforts to collect charges without jeopardizing client confidentiality." If a patient is insured on health insurance policies held in someone else's name, the clinic "must inform the client of any potential for disclosure of their confidential health information to policyholders."[106]

Parent Access

Title X implementation regulation, 42 C.F.R. 59.10(b), prohibits health care providers from notifying a parent before or after Title X services are requested or delivered to a minor, effectively requiring a minor's authorization in order to share with a parent any information about the minor generated during Title X services.[107] In Deanda v. Becerra, a parent claimed that implementation of Title X violated his rights under a Texas statute, which grants parents the right to consent to their child's medical care.[108] The Fifth Circuit Court of Appeals found that it is possible to follow both 42 U.S.C.300(a) and Texas' law, and held that Title X programs must follow Texas' state consent law.[109] The Court declined to address whether 42 C.F.R. 59.10(b) itself preempts Texas' parent consent law. Requiring parent consent effectively requires notice to parents before service delivery. However, in its decision in Deanda v. Becerra,[110] the Fifth Circuit did not address the confidentiality of the health information that would be disclosed or a parent's right to access that information. After this ruling, the U.S. Department of Health and Human Services' Office of Population Affairs (OPA) issued the following guidance:

> "OPA will not be enforcing 42 C.F.R. § 59.10(b) in the State of Texas, nor will it enforce that regulation elsewhere in the fifth circuit to the extent it conflicts with state law. OPA will continue to enforce § 59.10(b) throughout the rest of the country. Title X projects in states in the Fifth Circuit other than Texas may wish to consult with their own counsel regarding their states' requirements with respect to confidentiality."[111]

States in the Fifth Circuit include: Louisiana, Mississippi, and Texas.

In addition to the Title X statute and regulations, clinics also must follow applicable federal and state confidentiality law to the extent possible. As just one example, if the clinic is a "covered entity" subject to HIPAA, the clinic must follow the HIPAA Privacy Rule as well as Title X regulations.

Many federal laws affect the confidentiality of minors' health information when they consent for the care. These are discussed in detail in other Appendices and include: the HIPAA Privacy Rule (Appendix B), the

[105] 42 C.F.R. § 59.10(a).
[106] 42. C.F.R. § 59.10(a).
[107] 42. C.F.R. § 59.10(b)("To the extent practical, Title X projects shall encourage family participation. However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.").
[108] Texas Family Code § 151.001(a)(6) ("A parent of a child has the following rights and duties:…the right to consent to the child's marriage, enlistment in the armed forces of the United States, medical and dental care, and psychiatric, psychological, and surgical treatment").
[109] *Deanda v. Becerra*, 96 F.4th 750, 768 (5th Cir. 2024).
[110] *Deanda v. Becerra*, 96 F.4th 750, 768 (5th Cir. 2024).
[111] OPA Program Policy Notice: 2024-01—Clarification Regarding Confidential Services to Adolescents under the Title X Program, March 22, 2024, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/programpolicy-notices/opa-program-policy-notice-2024-01-clarification-regarding-confidential-services-to-adolescents-under-thetitle-x-program.

Part 2 (Appendix D), FERPA (Appendix E), billing and insurance claims (Appendix F), and the 21st Century Cures Act (Appendix G).

APPENDIX D[112]
42 CFR PART 2 AND CONFIDENTIALITY IMPLICATIONS FOR SUBSTANCE USE CARE FOR MINORS

What is Part 2?

Federal regulations, "Confidentiality of Substance Use Disorder Records"—contained in 42 CFR Part 2 and often referred to as "Part 2"—establish specific confidentiality protections for substance use disorder records.[113] Originally issued in 1975, and subsequently amended in 1987, 2017, and 2024,[114] the strong protections in these rules were intended to encourage individuals with substance use disorders to seek treatment, protect their privacy, and ensure that they not face adverse consequences in criminal or civil proceedings or employment.

Who is required to comply with Part 2?

When providing substance use disorder treatment services, health care providers must determine whether their records are subject to Part 2, which applies to "Part 2 programs."[115]

A Part 2 program is a "federally assisted program," as that term is defined in the regulations, that also meets certain other criteria. The definition of federal assistance is broad and includes being operated, authorized, certified, licensed, supported, or funded in whole or in part by any department of the federal government. Examples include federal, state, or local programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds whether used directly for the substance use disorder program or not; or registered with Medicare.[116]

To be considered a Part 2 program, an individual or program must also be an individual, an entity other than a general medical facility, or an identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.[117]

What is considered a substance use disorder under Part 2?

Substance use disorder is defined for purposes of Part 2 as a "cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal."[118] The definition does not include use of tobacco or caffeine.

What information does Part 2 protect?

Part 2 protects patient information in substance use disorder records. The Part 2 definition of "records" is broad and, with some exceptions, includes any information, whether recorded or not, created by, received,

[112] Appendix D copied from Appendix J of the National Center for Youth Law's *Minor Consent and Confidentiality A Compendium of State and Federal Laws, August 2024,* available at: https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024.pdf.
[113] 42 U.S.C. § 290dd-2; 42 C.F.R. Part 2.
[114] 89 Fed. Reg. 12472 (Feb. 16, 2024).
[115] 42 C.F.R. § 2.11, 2.12.
[116] 42 C.F.R. § 2.12.
[117] 42 C.F.R. §§ 2.11, 2.12.
[118] 42 C.F.R. § 2.11.

or acquired by a Part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts), and including patient identifying information.[119]

What confidentiality requirements does Part 2 impose?

For those providers and programs that must comply with the federal rules, the regulations impose strict confidentiality requirements that do not allow disclosure without the written consent of the patient except in specific circumstances that pose a substantial threat to the life or physical wellbeing of the patient or another person.[120]

There are a few exceptions that allow disclosure without written consent. For example, providers may disclose to medical personnel any information necessary to provide emergency treatment;[121] and providers may report child abuse or neglect as required by state law.[122] However, these exceptions allow disclosure only for those specific purposes.

Does Part 2 determine who consents for a minor's substance use disorder treatment?

No. Part 2 defers to state law on the issue of consent for minor's substance use disorder treatment. Whether state law allows minors acting independently to consent for their own substance use disorder treatment or requires parent or guardian consent has an impact on whose consent is required for disclosure of substance use disorder information and records to parents or third parties.

Do the Part 2 confidentiality rules apply to the records and information of minors?

Part 2 protects the information and records of minor patients as well as adults. When minors acting independently are allowed to access substance use disorder treatment under state law, they have independent rights under the regulations.[123]

Who is authorized to sign a release of information under Part 2?

When state law allows minors acting alone to apply for and obtain their own substance use disorder treatment, Part 2 generally requires the minor's written consent for disclosures.[124] Specific limitations apply to disclosures related to financial reimbursement.[125]

When state law requires parent or guardian consent for a minor's substance use disorder treatment, Part 2 generally prohibits disclosure to third parties without the written consent of both the minor and the minor's parent or guardian.[126]

Do parents/guardians have a right to access minors' information and records under Part 2?

[119] 42 C.F.R. § 2.11.
[120] 42 C.F.R. § 2.13.
[121] 42 U.S.C.§ 290dd-2(b)(2)(A).
[122] 42 C.F.R.§ 2.12(c)(6).
[123] 42 C.F.R. § 2.14.
[124] 42 C.F.R. § 2.14(a).
[125] 42 C.F.R. § 2.14(a).
[126] 42 C.F.R. § 2.14(b).

Part 2 addresses when a minor's written consent is required for disclosures.[127] There is also a general provision in 42.C.F. R. § 2.14(c) that sets out the criteria for when a minor's information may be disclosed to parents without the consent of the minor. Under this section, Part 2 allows disclosure to parents and guardians of "facts relevant to reducing a substantial threat to the life or physical wellbeing" of the minor or another person, without the minor's written consent, when the following three conditions are met, as determined by the Part 2 program director:

- the minor's situation poses a substantial threat to the life or physical well-being of the minor or another;
- this threat may be reduced by communicating relevant facts to the minor's parents; and
- the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to parents.[128]

When state law allows minors acting alone to apply for and obtain their own substance use disorder treatment, Part 2 generally requires the minor's written consent for disclosure, including disclosure to a parent or guardian.[129] However, when the criteria in 42 U.S.C. § 2.14 (c) are met, disclosure to parents of "facts relevant to reducing a substantial threat to the life or physical wellbeing" of the minor or another person would be allowed without the consent of the minor.

When state law requires parent or guardian consent for treatment, Part 2 specifies that the fact the minor applied for treatment may only be communicated to the minor's parent or guardian with the minor's consent if the criteria specified in 42 C.F.R. § 2.14(c) are satisfied.[130] When parent or guardian consent is required, Part 2 also allows disclosure to parents and guardians of "facts relevant to reducing a substantial threat to the life or physical wellbeing" of the minor or another person, without the minor's written consent if the criteria in 42 C.F.R. § 2.14(c) are met.

How has Part 2 changed with the new Part 2 Final Rule issued in 2024?

In February 2024, HHS issued a final rule modifying various provisions of Part 2.[131] Many provisions have remained the same; among the provisions that have not been modified are the specific requirements related to minors. These new rules are lengthy, detailed, and complex. Additional information about the rules will be forthcoming both from the federal government and from organizations with extensive expertise on Part 2, such as the Legal Action Center.

What is the relationship between Part 2, HIPAA, other federal laws, and state laws?

Part 2 programs must follow the Part 2 regulations. However, they may also be subject to other laws such as the HIPAA Privacy Rule, other federal statutes and regulations, and state laws. Usually, providers can comply with federal and state confidentiality laws at the same time. When state law conflicts with the federal rule, however, the law that best protects confidentiality applies.[132] To the extent that the Part 2 regulations are more protective of confidentiality, they take precedence over state law; if they are less protective, state law controls.[133]

[127] 42 C.F.R. § 2.14.
[128] 42 C.F.R. § 2.14(c).
[129] 42 C.F.R. § 2.14(a).
[130] 42 C.F.R. § 2.14 (b)(2) and (c).
[131] 89 Fed. Reg. 12472 (Feb. 16, 2024); see also, U.S. Department of Health and Human Services, Fact Sheet 42 C.F.R. Part 2 Final Rule (Feb. 8, 2024), https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html.
[132] 42 C.F.R. 2.3(b)(1).
[133] 42 C.F.R. § 2.20.

Many federal laws affect the confidentiality of minors' health information when they consent for the care. These are discussed in detail in other Appendices and include: HIPAA Privacy Rule (Appendix B), Title X (Appendix C), FERPA (Appendix E), billing and insurance claims (Appendix F), and the 21st Century Cures Act (Appendix G).

APPENDIX E[134]
FERPA AND CONFIDENTIALITY IMPLICATIONS FOR SCHOOL-BASED AND SCHOOL-LINKED HEALTH CARE FOR MINORS

What is FERPA?

The Family Educational Rights and Privacy Act (FERPA) protects the privacy of students' personal records held by "educational agencies or institutions" that receive federal funds under programs "administered by the U.S. Secretary of Education."[135] FERPA also assures access to educational records by a student's parents or by a student age 18 or older.

Who is required to comply with FERPA?

Educational agencies and school officials are required to follow FERPA. Organizations and individuals that contract with, or volunteer or consult for, an educational agency also may need to follow FERPA if certain conditions are met and they can be considered a "school official."[136]

"Educational agencies or institutions" are defined as institutions that receive federal funds under programs administered by the U.S. Department of Education (DOE) and that either provide direct instruction or educational services to students, such as schools; or are educational agencies that direct or control schools, including school districts and state education departments.[137]

The term "school official" includes school staff, such as teachers, counselors, and school nurses. It also can include a "board member, trustee, registrar, … attorney, accountant, human resources professional … and support or clerical personnel."[138] A school or district may define this term even more broadly in its school policies so that it also includes outside consultants, contractors, or volunteers to whom a school has outsourced a school function if certain conditions are met.[139]

What information does FERPA protect?

FERPA controls disclosure of personally identifiable information (PII) maintained in a student's "education record." "Education records" are defined as records, files, documents, or other recorded materials that contain information directly related to a student and are maintained by an educational agency or institution, or a person acting for such agency or institution.[140] "Information directly related to a student" means any information "that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community … to identify the student with reasonable certainty."[141] Education records may include health information.

FERPA does not apply to all information at a school. For example, communications that are not recorded in any form, such as personal knowledge or the contents of a conversation between a teacher and student in a hallway that is not recorded, are not part of the education record and are not subject to FERPA.

[134] Appendix E copied from Appendix K of the National Center for Youth Law's *Minor Consent and Confidentiality A Compendium of State and Federal Laws, August 2024,* available at: https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024.pdf.
[135] 34 C.F.R. § 99.1(a).
[136] See e.g., 34 C.F.R. § 99.31(a)(1)(i)(B).
[137] 34 C.F.R. § 99.1(a).
[138] DOE, Who is a "school official" under FERPA?. https://studentprivacy.ed.gov/faq/who-%E2%80%9Cschool-official%E2%80%9D-under-ferpa, accessed 9 March, 2023.
[139] See 34 C.F.R. § 99.31(a)(1)(i).
[140] 20 U.S.C. § 1232g (a)(4)(A).
[141] 34 C.F.R. § 99.3.

Several types of records are exempt from FERPA. The most relevant exemptions related to health information created at or held by schools include:

- records of a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional that are kept in the "sole possession" of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record;
- treatment records of a student age 18 years and older when used only in connection with treatment and not made available to anyone other than those providing treatment; and
- records of the law enforcement unit of an educational institution or agency.[142]

What are the requirements for disclosure of PII under FERPA?

Generally, FERPA prohibits educational agencies from releasing any "personally identifiable information"[143] in the education record unless they have written permission for the release.[144] Releases must include specific elements to be valid. There are exceptions that allow disclosure without a release in some cases.

In most cases, a "parent" must sign that release. FERPA defines parent broadly for this purpose to include a parent, guardian, or "person acting in the role of parent."[145] FERPA does not define what it means to be a "person acting in the role of a parent" for this purpose; however, state law or local educational agency policy may. When students are age 18 years or older, they must sign their own release forms.[146]

What are the rights of parents and students to access educational records?

Parents of a student under age 18 may access their child's education record.[147] FERPA defines "parent" to include a parent, guardian, or person acting in the role of parent.[148] The only exception is if a court order explicitly limits a parent's right to access the record. "Eligible students"— those age 18 years or older— have a right to access their own education records. Parents' access to the records of an eligible student are restricted and may require the agreement of the eligible student. However, it is important to note that, under FERPA, parents may have access to the education records of eligible students when they are claimed as dependents on the parents' most recent tax returns.[149]

How do FERPA and state laws interact?

In addition to laws that protect the confidentiality of medical and mental health information, states may also have laws that protect the confidentiality of education records. Whenever possible, educational agencies must comply with both FERPA and state law, even where state law may provide greater protection. To the extent that provisions of FERPA conflict with state statutes or regulations, FERPA usually preempts state law. However, if an educational agency believes there is an actual conflict between obligations under state law and its ability to comply with FERPA, the educational agency must notify the DOE's Family Policy Compliance Office.[150]

[142] 34 C.F.R. § 99.3.
[143] 34 C.F.R. § 99.3.
[144] 34 C.F.R. § 99.30(a).
[145] 34 C.F.R. § 99.3.
[146] 34 C.F.R. § 99.30(a).
[147] 34 C.F.R. § 99.31(a)(8).
[148] 34 C.F.R. § 99.3.
[149] 34 C.F.R. § 99.31(a)(8).
[150] 34 C.F.R. § 99.61.

How do FERPA and HIPAA intersect when services are delivered through school-based or school-linked care?

The HIPAA Privacy Rule applies to "personal health information" (PHI),[151] which includes individually identifiable health information created or received by a covered entity (most health care providers, health plans, or health care clearinghouses) in any form, including oral communications as well as written or electronically transmitted information.[152] PHI does not include information subject to FERPA. HIPAA explicitly states that health information in an education record subject to FERPA is not "protected health information."[153] In other words, if FERPA applies, HIPAA does not, even if a school employed health care provider otherwise qualifies as a covered entity under HIPAA. For example, if a school nurse provides health care to a student, the records of that care are subject to FERPA rather than HIPAA.

How do FERPA, HIPAA, and state laws intersect when services are delivered through school-based or school-linked care?

In determining whether FERPA, HIPAA, and/or state laws apply to records generated about school-based or school-linked health care, some basic principles are important to understand:

- If FERPA applies, HIPAA does not. FERPA and the HIPAA Privacy Rule can never apply at the same time because HIPAA excludes education records from the definition of protected health information.
- FERPA and state laws can apply at the same time. Whenever possible, educational agencies must comply with both FERPA and state law, even where state law may provide greater protection. To the extent that provisions of FERPA conflict with state law or regulation, FERPA usually preempts state law. However, if an educational agency believes there is an actual conflict between obligations under state law and its ability to comply with FERPA, the educational agency must notify the DOE's Family Policy Compliance Office.[154]
- Neither the HIPAA Privacy Rule nor FERPA may apply. There are situations in which health information created at school is not protected by either HIPAA or FERPA. In such cases, state law becomes determinative.

Many federal laws affect the confidentiality of minors' health information when they consent for the care. These are discussed in detail in other Appendices and include: the HIPAA Privacy Rule (Appendix B), Title X (Appendix C), Part 2 (Appendix D), FERPA (Appendix E), billing and insurance claims (Appendix F), and the 21st Century Cures Act (Appendix G).

[151] 45 C.F.R. § 164.502(a).
[152] 45 C.F.R. § 160.103.
[153] 45 C.F.R. § 164.103.
[154] 34 C.F.R. § 99.61.

APPENDIX F[155]
CONFIDENTIALITY IN HELATH INSURANCE CLAIMS AND BILLING

What confidentiality issues arise in the context of health insurance claims and billing?

The insurance claims and billing process implicates confidentiality and disclosure at two stages:

- First, a health care provider must disclose personally identifiable health information to an insurer or health plan when submitting a claim. If that information is protected by a confidentiality law, it only may be disclosed if a provision in the applicable law allows the disclosure.
- Second, once the insurer has the information, the insurer may choose or be required to share personally identifiable health information with the insurance policyholder as the claim is processed and acted upon. More often than not, this disclosure is the result either of explicit legal requirements, or of insurance carriers' policies and practices, such as the sending of explanations of benefits (EOBs) when insurance claims are filed and acted upon.

When the insurance policyholder and the patient are not the same person, these disclosures may result in patients' information reaching the family member who is the policyholder for the health insurance, even when the patient wants the information to remain private. This is of particular concern when the information pertains to sensitive health issues such as STIs, HIV, pregnancy, contraception, abortion, mental health, or substance use; or when an individual's safety would be jeopardized by disclosure. Protecting confidentiality in the health insurance arena is complex and has long presented recognized challenges, especially for adolescents and other individuals who are insured on a parent or family member's policy.1

Which laws control the confidentiality of health information in health insurance claims and billing?

Both federal and state laws contain numerous provisions that affect the confidentiality and disclosure of information at both stages of the health insurance claims and billing process.2 The confidentiality laws vary in terms of what information they protect, who can access the information, when the patient's permission is required for disclosure, and other factors.

Some of the federal laws that include important, but varied, requirements include the Title X Family Planning Program, FERPA, Part 2, and the HIPAA Privacy Rule.

State laws also contain important confidentiality protections and disclosure requirements that are relevant to health care billing. These include general medical confidentiality and medical records laws as well as laws related to specific health issues such as STIs, HIV, pregnancy, contraception, abortion, mental health, and substance use. A growing number of states have enacted statutes or issued regulations that specifically address confidentiality in health insurance claims and billing.

How do federal laws provide confidentiality protections relevant to health insurance claims and billing?

It depends. For example, federal Title X confidentiality provisions allow Title X funded providers to share information for purpose of collecting charges but must make "reasonable efforts to collect charges without jeopardizing client confidentiality." If a patient is insured on a health insurance policy held in someone else's name, the clinic "must inform the client of any potential for disclosure of their confidential health information to policyholders."[156]

[155] Appendix F copied from Appendix L of the National Center for Youth Law's *Minor Consent and Confidentiality A Compendium of State and Federal Laws, August 2024,* available at: https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024.pdf.
[156] 42 C.F.R. 59.10(a).

By contrast, both FERPA, which applies to education records, and 42 CFR Part 2, which applies to certain substance use records, require signatures to disclose protected information and make no exception to this requirement for reimbursement or billing, which means a health care provider must obtain a compliant release signed by the appropriate person, as defined by the applicable law, in order to submit a claim to an insurer (see Appendices J and K).

The HIPAA Privacy Rule adopts another approach by specifying the requirements for individuals to request that insurers either restrict disclosure or communicate in a confidential manner. These requirements of HIPAA are discussed in further detail below and in Appendix B.

What requirements of federal law lead health plans to disclose information to policy holders?

Various federal laws may result in health plans disclosing information to insurance policy holders.4 In particular, several federal laws require that insurers and health plans share information about denials of claims with policyholders, subscribers, and enrollees – as detailed in the Affordable Care Act (ACA), Employee Retirement Income Security Act (ERISA), and Medicaid Managed Care regulations.5 These denial notices are commonly sent in a format that looks like an explanation of benefits (EOB).

Does the HIPAA Privacy Rule offer any confidentiality protections for minors and other patients who do not hold their own insurance policies?

The federal HIPAA Privacy Rule requires health care providers and health insurers in every state to protect patients' privacy. HIPAA provides a floor of protection. States can offer more protection, but they cannot offer less. The regulation includes two special protections that facilitate restrictions on disclosure of protected health information (PHI) and provide for confidential communications in some circumstances.

The first special protection allows patients to request restrictions on the disclosure of their PHI.6 Health plans/ health insurers are not generally required to comply with such requests unless they agree to do so, but they must agree if the disclosure in question would be for purpose of carrying out payment and is not otherwise required by law and the care has been fully paid for by the patient or someone other than the health plan.

The second special protection allows patients to request their insurer send "communications of protected health information … by alternative means or at alternative locations." 7 A health plan must accommodate a reasonable request from an individual "if the individual clearly states that the disclosure of all or part of that information could endanger the individual." Thus, a health plan may condition the provision of a reasonable accommodation on: "(A) When appropriate, information as to how payment, if any, will be handled; and (B) Specification of an alternative address or other method of contact. The health plan also may require that a request contain a statement that "disclosure of all or part of the information to which the request pertains could endanger the individual."8

A minor may request these protections from their insurers when the minor has the authority to act as an "individual" for purposes of HIPAA, including but not limited to when a minor consents for their own health care under state law (See Appendix B).

Has New Mexico provided specific protections for confidentiality in insurance?
No.

APPENDIX G[157]
ELECTRONIC HEALTH INFORMAITON, THE 21ST CENTURY CURES ACT, AND CONFIDENTIALITY FOR MINOR PATIENTS

With the widespread adoption of electronic health records and patient portals as required by federal law, numerous questions have arisen concerning the confidentiality of minor patients' electronic health information and access to that information by parents and guardians. Federal laws, such as the HIPAA Privacy and Security Rules, have affected these issues for many years. More recently, the 21st Century Cures Act and its Information Blocking Rule have had a major impact on these questions.

What is the 21st Century Cures Act?

The 21st Century Cures Act, enacted in 2016, contains wide-ranging provisions related to the Food and Drug Administration (FDA), drug development, cancer research, the opioid crisis, and patient access to innovations.[158] The Cures Act affects patients, health care providers, payers, technology developers, and other health care and health IT stakeholders.

Among other things, the Cures Act required the Secretary of the U.S. Department of Health and Human Services to develop regulations to enhance patient access to and control of their health data, including rules to restrict blocking of access to and the exchange of electronic health information as well as to require interoperability and health IT certification. These regulations are referred to as the Information Blocking Rule.

What is the Information Blocking Rule and why is it important for minor patients?

On May 1, 2020, after a regulatory process lasting more than a year, the Office of the National Coordinator for Health Information Technology (ONC) published a final rule, "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program."[159] One of the key elements of this final ONC Rule is a prohibition on information blocking.[160] The original compliance date for the Rule's information blocking provisions was extended to April 5, 2021 in recognition of the pressures created by the COVID-19 pandemic.[161] The ONC website contains extensive material about the Rule, including the language of the Rule itself, fact sheets, and FAQs about information blocking.[162]

Although the Information Blocking Rule (the Rule) does not contain provisions specific to minors, implementation of the Rule has major implications for the confidentiality of minors' health information.[163]

[157] Appendix G copied from Appendix M of the National Center for Youth Law's *Minor Consent and Confidentiality A Compendium of State and Federal Laws, August 2024,* available at: https://youthlaw.org/wp-content/uploads/ncylminorconsentcompendium2024.pdf.
[158] 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033. Dec. 13. 2016.
[159] 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program. 85 Fed. Reg. 25642, May 1, 2020. https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf. Codified at 45 C.F.R. Parts 170 and 171.
[160] 45 C.F.R. Part 171.
[161] Information Blocking and the ONC Health IT Certification Program: Extension of Compliance Dates and Timeframes in Response to the COVID-19 Public Health Emergency.85 Fed. Reg. 70064, November 4, 2020. https://www.govinfo.gov/content/pkg/FR-2020-11-04/pdf/202024376.pdf.
[162] Information Blocking and the ONC Health IT Certification Program: Extension of Compliance Dates and Timeframes in Response to the COVID-19 Public Health Emergency.85 Fed. Reg. 70064, November 4, 2020. https://www.govinfo.gov/content/pkg/FR-2020-11-04/pdf/202024376.pdf.
[163] Pasternak RH, Alderman EM, English A. 21st Century Cures Act ONC Rule: Implications for Adolescent Care and Confidentiality Protections. Pediatrics 2023;151(S1), April 2023:e2022057267K. http://doi:10.1542/peds.2022-057267K.

In order to understand these implications, it is necessary to understand the requirements of the Rule itself as well as the way it intersects with other federal and state laws.

Who is required to comply with the Information Blocking Rule?

The Information Blocking Rule applies to "health care providers, health IT developers of certified health IT, health information exchanges, and health information networks[.]"[164] This appendix focuses on Information Blocking Rule implementation issues for health care providers.

To what information and records does the Information Blocking Rule apply?

The Information Blocking Rule applies to most "electronic health information" (EHI),[165] including "individually identifiable health information" that is "transmitted by" or "maintained in" electronic media, as specified in HIPAA.[166] From the beginning, the Information Blocking Rule has applied to a very broad range of patient information including clinical notes, laboratory tests and results, medications, health concerns, problems, and procedures.[167] On October 6, 2022, the scope of information subject to the Information Blocking Rule was expanded to include the full range of EHI, including not only medical records but also billing records maintained by a health care provider as well as enrollment, payment, and claims information of a health plan.[168]

Of importance, the Information Blocking Rule specifically states that the EHI to which the Rule applies does not include psychotherapy notes, as defined in HIPAA,[169] and also does not include information compiled in reasonable anticipation of, or for use in, civil, criminal, or administrative proceedings.[170]

What constitutes information blocking?

Information blocking is defined, for a health care provider, as a "practice" that is likely to interfere with "access, exchange, or use" of EHI if the provider knows both that the practice is "unreasonable" and also that it is likely to interfere with access, exchange, or use of the EHI.[171] This terminology can be confusing and covers many different actions by health care providers and health systems. A few general examples of what is considered information blocking include:

- "Formal restrictions," such as a provider or office policy requiring staff to obtain a patient's written consent before sharing any EHI with unaffiliated providers for treatment purposes
- "Technical limitations," such as a physician disabling the use of an EHR capability that would enable staff to share EHI with users at other systems
- "Isolated interferences," such as a physician who has the capability to provide same-day EHI access in a format requested by an unaffiliated provider—or by their patient—but takes several days to respond to an access request[172]

How is the Information Blocking Rule affecting confidentiality of minor patients' health information?

[164] 45 C.F.R. § 171.101(a) (emphasis added).
[165] 45 C.F.R. §171.102.
[166] 45 C.F.R. § 160.103.
[167] USCDI v1 Summary of Data Classes and Data Elements. https://www.healthit.gov/isa/sites/isa/files/2020-10/USCDI-Version-1-July-2020Errata-Final_0.pdf.
[168] Information Blocking: Eight Regulatory Reminders for October 6th. https://www.healthit.gov/buzz-blog/information-blocking/informationblocking-eight-regulatory-reminders-for-october-6th.
[169] 45 C.F.R. § 164.501.
[170] 45 C.F.R. § 171.102.
[171] 45 C.F.R. § 171.103.
[172] https://www.ama-assn.org/system/files/2021-01/information-blocking-part-1.pdf.

The Information Blocking Rule has enormous potential to result in the disclosure of minor patients' health information, including disclosure to parents or guardians of information the minor considers sensitive. Many of these disclosures occur when information is released to a minor patients' portal and parents/guardians have access to the portal either formally as proxies or informally because they have the minor patients' password. This can include, but is not limited to, disclosure of visit notes about discussion of sensitive topics; laboratory results of STI, HIV, or pregnancy tests; and after visit summaries that list prescription medications such as contraceptives.[173]

The architecture of current EHR systems, in many cases, has not been developed to allow for sufficiently granular segmentation of EHI, which means the systems are not able to ensure that parents may access the health information they are legally entitled to see while also ensuring information that must remain confidential under state or federal law is separately protected. This has led health systems that specialize in caring for adolescents to implement widely varied approaches in their efforts both to comply with the Information Blocking Rule and to provide confidentiality protections consistent with ethical standards and legal requirements.[174]

Are there exceptions that allow health care providers to block information without violating the Rule?

The Information Blocking Rule recognizes eight exceptions that specify when actions that would otherwise be considered information blocking will not be treated as such. These exceptions include:

- Preventing Harm Exception[175]
- Privacy Exception[176]
- Security Exception[177]
- Infeasibility Exception[178]
- Health IT Performance Exception[179]
- Content and Manner Exception[180]
- Fees Exception[181]
- Licensing Exception[182]

A health care provider's practice is not considered information blocking if it meets all the applicable requirements and conditions of at least one of the exceptions.[183] Two of these exceptions are highly relevant for health care providers who treat adolescent minors: the Preventing Harm Exception and the Privacy Exception.

What are the requirements for invoking the Preventing Harm Exception?

To satisfy the conditions for the Preventing Harm Exception:

[173] Pasternak RH, Alderman EM, English A. 21st Century Cures Act ONC Rule: Implications for Adolescent Care and Confidentiality Protections. Pediatrics 2023;151(S1), April 2023:e2022057267K. http://doi:10.1542/peds.2022-057267K.
[174] Ford CA, Bourgeois F, Buckelew SM, et al. Twenty-First Century Cures Act Final Rule and adolescent health care: Leadership Education in Adolescent Health (LEAH) program experiences. J Adolesc Health. 2021;69(6):873-877. http://doi:10.1016/j.jadohealth.2021.09.006.
[175] 45 C.F.R. § 171.201.
[176] 45 C.F.R. § 171.202.
[177] 45 C.F.R. § 171.203.
[178] 45 C.F.R. § 171.204.
[179] 45 C.F.R. § 171.205.
[180] 45 C.F.R. § 171.301.
[181] 45 C.F.R. § 171.302.
[182] 45 C.F.R. § 171.303.
[183] 45 C.F.R. § 171.200.

- A health care provider must have a "reasonable belief" that their practice will "substantially reduce a risk of harm to a patient or another natural person"[184] and
- The practice must be "no broader" than necessary.[185]

In addition, the risk of harm must either:

- Be determined on an individualized basis in the exercise of professional judgment by a licensed health care professional who has a current or prior clinician-patient relationship with the affected patient;[186] or
- Arise from misidentified, mismatched, corrupted, or erroneous data.[187]

Also, the type of harm being prevented must be one of the specific types that the HIPAA Privacy Rule[188] recognizes as a basis for denying access to a patient's PHI.[189] Those types of harm are further explained in the next section.

If the risk of harm is determined on an individualized basis, a patient must be able to exercise any rights they have under HIPAA or under other federal, state, or tribal laws, to request a review and possibly a reversal of the individualized determination.[190]

Finally, implementation of the practice must either: be consistent with an organizational policy; or, in the absence of a policy, be based on a determination that meets certain conditions.[191]

Any such organizational policy must:

- Be in writing;
- Be based on relevant clinical, technical, or other expertise;
- Be implemented in a consistent and non-discriminatory manner; and
- Conform to the other conditions required for relying on the Preventing Harm Exception.[192]

To summarize, important conditions for relying on the Preventing Harm Exception include:

- A reasonable belief that the practice will substantially reduce a risk of harm
- A practice that is no broader than necessary
- A risk of harm determined by the exercise of clinical judgment
- An opportunity for a patient to request review of the risk of harm determination
- A type of harm recognized by the HIPAA Privacy Rule for denying access to PHI
- An organizational policy that meets certain requirements

What types of harm justify reliance on the Preventing Harm Exception?

The Information Blocking Rule aligns the Preventing Harm Exception with certain provisions of the HIPAA Privacy Rule for determining when patients have access to their own health information. The HIPAA Privacy Rule allows health care providers to deny patients access to their PHI in specific circumstances

[184] 45 C.F.R. § 171.201(a).
[185] 45 C.F.R. § 171.201(b).
[186] 45 C.F.R. § 171.201(c)(1).
[187] 45 C.F.R. § 171.201(c)(2).
[188] 45 C.F.R. Parts 160 and 164.
[189] 45 C.F.R. § 171.201(d).
[190] 45 C.F.R. § 171.201(e).
[191] 45 C.F.R. § 171.201(f).
[192] 45 C.F.R. § 171.201(f)(1).

when there is a reasonable likelihood of harm to the patient or another person as long as the patient can request review of the denial.[193]

In the early days of implementation of the Information Blocking Rule, confusion arose regarding whether the Preventing Harm Exception only applied when there was a risk of physical harm or death, or whether it would also apply in situations involving other substantial harm, including emotional or psychological harm. ONC has clarified that the Preventing Harm Exception is not limited to risks of physical harm or death; however, specific limitations do apply.

According to ONC, "[t]he Preventing Harm Exception's type of harm condition relies on the same types of harm that serve as grounds for reviewable denial of an individual's right of access under the [HIPAA] Privacy Rule."[194] Also, ONC provides a table that sets out the specific circumstances in which different types of harm support reliance on the Preventing Harm Exception.[195] This table contains references to the corresponding sections of the Information Blocking Rule and the HIPAA Privacy Rule.

According to ONC's table:

- When a patient is exercising their own right of access to their EHI, the applicable type of harm is danger to life or physical safety of the patient or another person.
- When a patient is exercising their own right of access to their EHI, which contains references to another person, the applicable type of harm is substantial harm to the other person.
- When a patient's personal representative (as defined in HIPAA) is exercising their right of access to the patient's EHI, the applicable type of harm is substantial harm to the patient or another person.
- When a patient's personal representative (as defined in HIPAA) is exercising their right of access to the patient's EHI, which contains references to another person, the applicable type of harm is substantial harm to the other person.

Under HIPAA, and therefore for purposes of the Preventing Harm Exception under the Information Blocking Rule, "substantial harm" includes "substantial physical, emotional, or psychological harm."[196]

Does the Preventing Harm Exception apply to minor patients' EHI?

ONC has clarified that the Preventing Harm Exception may cover a practice that interferes with a parent or guardian's access to a minor child's EHI if the conditions for the exception are met and an individualized determination has been made. The applicable standard is "substantial harm" and therefore would include emotional or physical as well as psychological harm.[197]

This situation might arise when a minor can legally access health care based on their own consent and disclosure of information about the care to a parent might result in harm. When an unemancipated minor is

[193] 45 C.F.R. § 164.524(a)(3).
[194] ONC. FAQ: Do the Preventing Harm Exception requirements for the type of harm align with the HIPAA Rules? https://healthit.gov/faq/do-preventing-harm-exception-requirements-type-harm-align-hipaa-rules/.
[195] ONC. FAQ: In which patient access cases does the Preventing Harm Exception recognize "substantial harm"? https://healthit.gov/faq/which-patient-access-cases-does-preventing-harm-exception-recognize-substantial-harm/.
[196] HIPAA Privacy Rule preamble at 65 FR 82556.
[197] ONC. FAQ: Where the patient is a minor and to reduce a risk of harm other than physical abuse, will the Preventing Harm Exception cover an actor's practices that interfere with a parent or legal guardian's access, exchange, or use of the minor's EHI? https://healthit.gov/faq/where-patient-minor-and-reduce-risk-harm-other-physical-abuse-will-preventing-harm-exception/.

legally authorized to consent for their own care and does so, the HIPAA Privacy Rule treats that minor as an "individual" and their parent is not automatically their personal representative.[198]

Reliance on the Preventing Harm Exception might also occur when a health care provider has a reasonable belief that the minor either has been or may be subjected to abuse or could be endangered, and the provider's professional judgement is that granting access is not in the minor's best interest; this is also a situation in which the HIPAA Privacy Rule allows a health care provider to deny a parent access to a minor's PHI.[199]

What are the requirements for invoking the Privacy Exception?

The Information Blocking Rule specifies four different situations or "sub-exceptions" that could support reliance on the Privacy Exception as a basis for not granting a request for access, exchange, or use of a patient's EHI:

- Preconditions required by state or federal law have not been satisfied[200]
- Situations involving health IT developers of certified health IT not covered by HIPAA[201]
- Denial of an individual's request for their EHI as allowed by HIPAA[202] or
- Respecting an individual's request not to share information[203]

All of the conditions for at least one of these sub-exceptions must be satisfied in order to rely on the Privacy Exception. Each of these sub-exceptions includes multiple specific conditions, which are set out in the regulatory language. Two of the sub-exceptions with great relevance for health care providers offering sensitive services to their patients, including adolescent minor patients, are: the sub-exception that involves compliance with state or federal law; and the sub-exception that involves an individual's request not to share information.

Are providers actions that withhold information treated as information blocking if they are required by law?

A practice that is "required by law" is not considered information blocking, even if it interferes with access, exchange, or use of a patient's EHI.[204] Although closely related to situations that fall under the Privacy sub-exception for compliance with state or federal law, such a situation is not treated as an exception to information blocking because it is not considered information blocking and thus does not require an exception. Therefore, when withholding EHI is required by law the conditions for the Privacy sub-exception based on compliance with state or federal do not have to be satisfied.

What are the conditions for the Privacy sub-exception based on compliance with state or federal law?

Many state and federal laws establish preconditions for release of a patient's health information, including their EHI.

If the preconditions of the relevant state or federal law are not satisfied, a health care provider may rely on the Privacy Exception to refrain from granting access, exchange, or use if the practice: Is tailored to the precondition that is not satisfied; and either

- Conforms to organizational policies that meet certain criteria; or

[198] 45 C.F.R. § 164.502(g)(3).
[199] 45 C.F.R. § 164.502(g)(5).
[200] 45 C.F.R. § 171.202 (b).
[201] 45 C.F.R. § 171.202 (c).
[202] 45 C.F.R. § 171.202 (d).
[203] 45 C.F.R. § 171.202 (e).
[204] 45 C.F.R. § 171.103(a)(1).

- Is documented with certain specificity on a case-by-case basis.[205]

What are the conditions for the Privacy sub-exception based on a patients' request not to share information?

If an individual requests that a health care provider not share their information—i.e., not provide access, exchange, or use of the information—the health care provider may choose to respect the request and refrain from sharing the information if certain requirements are met:

- the health care provider has not improperly encouraged or induced the request;
- the request is documented within a reasonable time;
- the practice of respecting such requests is implemented consistently and in a non-discriminatory manner; and
- the health care provider follows additional requirements related to any termination of compliance with the patient's request.[206]

The individual who makes such a request might be a patient or the patient's personal representative. For the purpose of the Privacy Exception, the Information Blocking Rule defines "individual" by reference to the HIPAA Privacy Rule.[207] Because the HIPAA Privacy Rule treats unemancipated minors as the "individual" when they are authorized to consent to their own care or meet other criteria,[208] it appears that minors who are legally allowed to consent for their own care may also be authorized to make requests that health care providers refrain from sharing their information under the Privacy Exception.[209]

What is the relationship between the Information Blocking Rule, other federal laws, and state laws?

Many federal laws apart from the Cures Act and the Information Blocking Rule are relevant when implementing the Rule. The federal law that is most closely intertwined with the Information Blocking Rule is HIPAA. Many provisions of the Information Blocking Rule contain cross references to definitions and requirements in the HIPAA Privacy Rule and HIPAA Security Rule.

In addition to the HIPAA Privacy Rule, other federal laws contain provisions that protect the privacy of patients' health information, including EHI, or require disclosure of that information under specific circumstances. These laws include confidentiality statutes and regulations pertaining to the Title X Family Planning Program;[210] Federally Qualified Health Centers,[211] Part 2—Substance Use Disorder Records,[212] Medicaid,[213] Ryan White HIV/AIDS Program,[214] and the Federal Educational Rights and Privacy Act (FERPA).[215] In addition to the federal laws, many state laws contain privacy protections. The Privacy Exception in the Information Blocking Rule permits reliance on these federal and state laws as long as the necessary conditions are met.

[205] 45 C.F.R. § 171.102(b)(1).
[206] 45 C.F.R. § 171.202(d).
[207] 45 C.F.R. §171.202(a)(2).
[208] 45 C.F.R. § 164.502(g)(3).
[209] This is an interpretation of the National Center for Youth Law. Prior to acting on this interpretation, it should be confirmed with legal counsel.
[210] 42 C.F.R. § 59.10.
[211] 42 U.S.C. § 254b(k)(3)(C); 42 C.F.R. § 51c.110. See also, 42 C.F.R. § 51c.110. National Association of Community Health Centers. Health Information Technology. https://www.nachc.org/health-center-issues/health-information-technologies-hit/.
[212] 42 C.F.R. Part 2
[213] 42 U.S.C. § 1396a(a)(7).
[214] 42 U.S.C. §§ 300ff-61, 300ff-62.
[215] 20 U.S.C. § 1232g; 34 C.F.R. Part 99.

To the extent that any of these laws require a practice that would interfere with access, exchange, or use of a patient's EHI, that practice would not be considered information blocking under the information Blocking Rule.[216]

Many of the federal laws that affect the confidentiality of minors' health information when they consent for the care are discussed in detail in other Appendices. They include: HIPAA Privacy Rule (Appendix B), Title X (Appendix C), Part 2 (Appendix D), FERPA (Appendix E), billing and insurance claims (Appendix F), and the 21st Century Cures Act (Appendix G).

[216] 45 C.F.R. § 171.103(a)(1).

APPENDIX H
SUMMARY OF STATE CONSENT LAWS

New Mexico Health Care Consent Laws for Minors*

New Mexico Minor Consent Laws Based on Status				
Status	**Minor Consent**	**Scope/Limitations**	**Citations**	**Year Enacted**
Age of majority†	< 18 – No ≥ 18 – Yes	Age of majority is 18	N.M. Stat. Ann. § 28-6-1	1971
Emancipated Minor	Yes	Emancipated minor may make his or her own health care decisions; consent for hospital, medical, surgical, dental, or psychiatric care	N.M. Stat. Ann. § 24-10-1 N.M. Stat. Ann. § 32A-21-5 N.M. Stat. Ann. § 24-7A-2	1963 1995 1995
Minor Living Apart	Yes	Unemancipated minor age 14 or older with capacity to consent living apart from parent or legal guardian may consent to medically necessary health care	N.M. Stat. Ann. § 24-7A-6.2	2009
Married minor	Yes	Minor age 16 or older who is or has been married may consent for hospital, medical, or surgical care	N.M. Stat. Ann. § 24-10-1 N.M. Stat. Ann. § 32A-21-3	1963 1995
Minor parent	Yes	Minor age 14 or older with capacity to consent who is a parent may consent to "medically necessary health care"	N.M. Stat. Ann. § 24-7A-6.2	2009
Minor in military	Yes	Minor age 16 or older on active military duty is emancipated	N.M. Stat. Ann. § 32A-21-3 N.M. Stat. Ann. § 23A-21-5 N.M. Stat. Ann. § 24-10-1	1995 1995 1963
New Mexico Minor Consent Laws Based on Services				
Service	**Minor Consent**	**Scope/Limitations**	**Citations**	**Year Enacted**
Emergency care	Consent by person other than parent	When minor needs immediate emergency hospitalization, medical attention, or surgery & parents cannot be located after reasonable efforts, any person standing in lieu of parents may consent	N.M. Stat. Ann. § 24-10-2	1963
Contraceptives/ family planning	Yes	State or local government or any health facility furnishing family planning services shall nor subject any person to any standard or requirement as a prerequisite to the receipt of family planning service except in specified circumstances not related to age (Note: See Appendix C 2 re Title X Family Planning)	N.M. Stat. Ann. § 24-8-2 N.M. Stat. Ann. § 24-8-5	1973 1973
Pregnancy care	Yes	Minor may consent for examination and diagnosis for pregnancy and, for female minors, for prenatal, delivery, and postnatal care.	N.M. Stat. Ann. § 24-1-13 N.M. Stat. Ann. § 24-1-13.1	1973 2001
STI care	yes	Minor may consent for examination, preventive care and treatment for any STI; counseling and referral must be provided to individuals with positive test result.	N.M. Stat. Ann. § 24-1-9 N.M Stat. Ann. § 24-1-9.3	1973 1996
HIV testing	yes	Minor may give informed consent for an HIV test; counseling and referral must be provided to individuals with positive test result.	N.M. Stat. Ann. § 24-2B-2 N.M. Stat. Ann § 24-2B-3 N.M. Stat. Ann § 24-2B-4	1989 1989 1989
Mental and behavioral health & substance abuse services ≥ age 14	Yes	Minor age 14 or older with capacity to consent may consent to treatment without consent of the child's legal custodian, including psychotherapy, group psychotherapy guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions or special ed services; capacity is presumed and determination of lack of capacity must be made by two clinicians; legal custodian cannot place child in residential treatment program if child does not consent.	N.M. Stat. Ann. § 32A-6A-14 N.M. Stat. Ann. § 32A-6A-15 N.M. Stat. Ann. § 32A-6A-16	2007 2007 2007
Mental health & substance abuse services < age 14	Yes, with limitations	Minor under age 14 may consent to initial assessment & verbal therapy for 2 weeks.	N.M. Stat. Ann. § 32A-6A-14	2007
Residential mental health & substance abuse treatment	Yes, with limitations	Specific consent rules govern voluntary and involuntary placement of minors in residential treatment facilities; separate rules apply to minors under age 14 & minors age 14 or older.	N.M. Stat. Ann. § 32A-6A-20 N.M. Stat. Ann. § 32A-6A-21 N.M. Stat. Ann. § 32A-6A-22	2007 2007 2007
Blood donation ≥ 17	Yes	Minor who is at least age 17 may donate blood to a licensed, accredited or approved blood bank, storage facility, or hospital without parental consent.	N.M. Stat. Ann. § 24-10-6	2003

* This table contains only brief summary information about the laws; New Mexico state laws are contained in Appendix A.

Source: National Center for Youth Law

† Parent consent is generally required for minors under age 18 unless one of the exceptions in the minor consent laws apply; young adults age 18 or older generally may consent for themselves.

APPENDIX I
SUMMARY OF STATE AND FEDERAL DISCLOSURE LAWS

NEW MEXICO & FEDERAL CONFIDENTIALITY LAWS FOR MINORS*

New Mexico Confidentiality Laws for Minors			
	Scope of Protection/Limitations	**Citations**	**Year Enacted**
Mental health and substance abuse information – access	Minor may access own confidential mental health and substance abuse information unless treating professional believes disclosure would not be in minor's best interest.	N.M. Stat. Ann. § 32A-6A-24	2007
Mental health and substance abuse information – disclosure	Consent of minor age 14 or older required for disclosure of confidential mental health and substance abuse information; minor age 14 or older authorized to consent for disclosure; custodian of minor younger than age 14 authorized to consent for disclosure on behalf of minor; specific exceptions allow disclosure without consent of minor or custodian.	N.M. Stat. Ann. § 32A-6A-24	2007
Parent as personal representative	Consistent with HIPAA, if minor authorized to consent for health care the minor has a right to determine whether parent is personal representative with access to minor's protected health information.	N.M. Admin. Code § 8.8.5.12	
Disclosure – STI and HIV test results	Identity of person tested for STI or HIV and test results shall only be disclosed to subject of test or legally authorized representative, guardian, or custodian (which could include parent).	N.M. Stat. Ann. § 24-1-9.4 N.M. Stat. Ann. § 24-2B-6	1996 1989
Disclosure - psychotropic drugs	If minor age 14 or older gives consent for administration of psychotropic drugs clinician must inform legal custodian of minor.	N.M. Stat. Ann. § 32A-6A-15	2007
Child abuse reporting	Every person, including health care professionals, who knows or suspects that a child has been abused due to action or inaction of parent must report to law enforcement or Children, Youth & Famlies Department.	N.M. Stat. Ann. § 32A-4-2 N.M. Stat. Ann. § 32A-4-3	1993 1993
Federal Confidentiality Laws for Minors			
	Scope of Protection/Limitations	**Citations**	
HIPAA Privacy Rule – minor as individual	Minor who consents, or whose parent accedes to confidentiality, is an "individual" with control over their own protected health information (PHI).	45 C.F.R. § 164.502(g)(3)	
HIPAA Privacy Rule – parent as personal representative	Parent not necessarily the personal representative when minors have consented to their own care; parent may not be personal representative if minor subject to domestic violence, abuse, neglect, or endangerment.	45 C.F.R. § 164.502(g)(3) and (5)	
HIPAA Privacy Rule – parents' access	Parents' access to PHI when minor is the "individual" depends on other state and federal laws; parent's access may be denied if health care professional determines It would cause substantial harm to minor or another individual.	45 C.F.R. §§ 164.502(g)(3) 164.524(a)(3)(iii)	
FERPA	Information about health services provided by a school may be included in a students' "education records" and subject to FERPA, not HIPAA; parents have access to minors' education records.	20 U.S.C §1232g 34 C.F.R. Part 99 45 C.F.R. § 160.103	
Title X Family Planning	Information about family planning services received at Title X funded sites is confidential and may only be disclosed with the minor's permission or if required by law.	42 C.F.R. § 59.11	
Medicaid	Adolescent minors who are eligible for Medicaid may receive confidential family planning services funded by Medicaid.	42 U.S.C. §§ 1396a(a)(7) 1396d(a)(4)(C)	
Drug & alcohol—"substance use disorder"—programs	In federally assisted programs, consent for disclosure must be obtained from minor who is authorized under state law to consent for alcohol or drug abuse treatment; disclosure to parents may occur only if minor lacks capacity for rational choice due to extreme youth, physical incapacity, or substantial threat to minor or another.	42 C.F.R. § 2.14	

Source: National Center for Youth Law

*This table includes information about selected state and federal confidentiality laws that pertain to minors' health information. It contains only brief summary information about the laws; more detailed information is included in Appendicies A through G. This table includes laws that are specific to minors; additional laws that are relevant for adults and minors are included in Table 3.


OFFICE'S SEAL OF THE STATE OF NEW MEXICO
CRESCIT EUNDO
1912