



# CLINICAL GUIDELINES PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV • HCV • STIs • SUBSTANCE USE • LGBTQ+ HEALTH

## Guidance: Adolescent Consent to HIV and STI Treatment and Prevention

### Updates, Authorship, and Related Resources

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Highlights of changes, additions, and updates in the May 8, 2024 edition	Resources, citations, and references updated throughout this guidance.
Intended users	New York State clinicians who provide primary care to adolescents (<18 years old)
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Related NYSDOH AI resources	<b>Guidelines</b> <ul style="list-style-type: none"><li>• <a href="#">PrEP to Prevent HIV and Promote Sexual Health</a></li><li>• <a href="#">PEP to Prevent HIV Infection</a></li></ul> <b>Guidance</b> <ul style="list-style-type: none"><li>• <a href="#">U=U Guidance for Implementation in Clinical Settings</a></li></ul> <b>Podcast</b> <ul style="list-style-type: none"><li>• <a href="#">Viremic—Cases in HIV</a></li></ul>

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## Purpose of This Guidance

This guidance was developed by the New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program. Its purpose is to inform New York State clinicians who provide primary care to adolescents about existing regulations that allow minors (<18 years old) to consent for and receive confidential HIV and sexually transmitted infection (STI) screening and treatment and biomedical HIV prevention in the form of pre- or post-exposure prophylaxis (PrEP or PEP).

Many adolescents in New York State self-report being sexually active, with approximately 40% of high school students reporting that they engaged in sexual intercourse by 12th grade[CDC 2021]. Sexually active youth are disproportionately affected by STIs compared with adults: 47% of all reported STIs are among young people, yet this age group represents only about 13% of New Yorkers. These available data represent only a portion of the true burden because many cases go undiagnosed, unreported, and untreated[NYSDOH 2022]. Public health concerns regarding adolescent burden of HIV also exist, given that approximately 20% of young people are not linked to care within 30 days of HIV diagnosis and those within care have lower rates of HIV viral suppression (70%) than the overall state rate (79%)[NYSDOH 2023].

**Ensuring appropriate care delivery:** The primary goal for clinicians treating minors living with HIV is providing appropriate care that prevents HIV disease progression and transmission. In providing healthcare for minors at risk of acquiring HIV, clinicians play a pivotal role in helping to end the HIV epidemic by:

- Identifying minors who may benefit from [PrEP](#) and [PEP](#)
- Providing education and counseling about PrEP and PEP use, so that they may be accessed when needed
- Ensuring confidentiality and preventing accidental disclosure of HIV status
- Ensuring retention in care with provision of combination antiretroviral therapy to promote achievement of [“Undetectable = Untransmittable” \(U=U\)](#)

**Reducing barriers to care:** To help reduce barriers and delays in accessing care, [New York State law allows minors to seek HIV prevention and treatment](#) without disclosing to or obtaining consent from a parent or guardian. This guidance does not intend to minimize the role of supportive parents, guardians, or other adults who may provide additional support to help adolescent patients adhere to their treatment plans.

**Retention in care:** Adolescents with HIV should be encouraged to remain in care and keep scheduled appointments. Adolescents may consent to and are eligible for all of the following essential medical services:

- Prescription and management of antiretroviral therapy
- Standard disease monitoring (e.g., physical and laboratory assessments such as CD4 counts and viral load tests)
- Screening and treatment for STIs
- Recommended immunizations, including for human papillomavirus (see [Centers for Disease Control and Prevention > Immunization Schedules](#))
- Sexual health and family planning services. In New York State, minors can consent to all forms of contraception, including condoms, emergency contraception, and long-acting methods, such as implants. Minors may also consent to abortion services without parental involvement (see [New York Civil Liberties Union: Teenagers, Health Care, and the Law: A Guide to the Law on Minors' Rights in New York State](#)).
- Counseling and treatment for risk reduction, mental health, and substance use, as permitted by law

## New York State Law and Federal Law

**Minors consent in New York State:** According to [New York State Public Health Law Article 23, Title 1, Section 2305](#), individuals <18 years old may give effective informed consent for services related to screening, treatment, and prevention of STIs, including HIV (see also [New York Codes, Rules and Regulations \[NYCRR\], Title 10, Section 23.4](#)). See the NYSDOH document [Frequently Asked Questions: Guidance for Local Health Departments \(LHD\) and Health Care Providers on STI Billing and Minor's Consent to Prevention Services and HIV-related Services](#).

Minor consent laws vary by state, and clinicians should be familiar with state laws. Clinicians who practice outside of New York State should be familiar with local and state laws, as well as with institutional policies to obtain guidance on how to care for minors living with or at risk for HIV who are unable or unwilling to disclose this to their parents or guardians, with the understanding that current evidence strongly favors early treatment for improved individual and public health outcomes.

**Immunization reporting in New York State:** The New York State [Immunization Registry Law](#) requires healthcare providers to report the immunization history for and all immunizations administered to patients <19 years old using the New York State Immunization Information System or, in New York City, to the Citywide Immunization Registry. There are no exemptions to the reporting mandate, so vaccination against human papillomavirus (HPV) is required as well. Minors who independently consent to vaccination against HPV should be advised of these reporting requirements and further advised that any immunization-specific information reported to the New York State or New York City systems may be requested by a parent or guardian[NYSDOH 2019].

**Federal law:** Federal law [45 CFR §164.524](#) requires that healthcare providers give patients access without charge to all of the health information in their electronic medical records. There are many potential advantages to sharing health information with patients and families. However, there are important implications for minors who access confidential services, including but not limited to HIV screening, treatment, and prevention. Individual organizations can choose how to share information with parents of minors and with minor patients themselves, and it is the responsibility of each organization to do so in a manner that maintains the right of adolescent minors to access confidential care. Healthcare providers should become familiar with their institutional policies regarding health information sharing for minors, should advocate for policies that incorporate adolescent confidentiality protections, and should be able to provide guidance to minors on how to access and protect their health information.

### ◇ NYSDOH RESOURCES

- [HIV Testing, Reporting and Confidentiality in New York State 2023 Update: Fact Sheet and Frequently Asked Questions: Question 5: Expansion of Minor Consent for HIV Treatment and Preventive Services](#)
- [HIV Testing Toolkit 2023 Update: Resources to Support Routine HIV Testing for Adults and Minors](#)
- [NYSDOH Letter: Explanation of 2017 changes to New York State law regarding the right of minors to consent for sexually transmitted disease \(STD\) and HIV prevention and treatment services](#)
- [Frequently Asked Questions: Guidance for Local Health Departments \(LHD\) and Health Care Providers on STI Billing and Minor's Consent to Prevention Services and HIV-related Services](#)

## Disclosure, Consent, and Confidentiality

**Disclosure:** It is important that clinicians engage adolescent patients in dialogue about the potential advantages or disadvantages of disclosing their HIV status to parents, legal guardians, or any other adult who may provide support and that they facilitate such conversations at a patient’s request. Determining whether a minor’s health or well-being may be at risk if they disclose their HIV status to their parent or legal guardian is crucial to establishing a framework for patient care. It is important to know, for example, if a young man who has sex with men may risk being forced out of his home if he discloses his HIV status or his sexual identity to his parents or legal guardians or if a young woman who has acquired HIV through sexual transmission may fear physical abuse if her family learns of her sexual activity.

### → KEY POINTS

- Adolescents may be at risk of abuse if they disclose that they have HIV or are at risk of acquiring HIV. Appropriate referrals and assistance should be offered to patients reporting such risk.
- Discussions about disclosure and possible risks to the adolescent can be documented in the medical record.
- Supportive adults may be an important resource to help adolescent patients remain engaged in care. Clinicians can help patients identify supportive adults and facilitate conversations around disclosure if requested.

**Consent and confidentiality:** Many healthcare facilities have established policies and procedures for obtaining consent for minors to receive HIV care, including prevention. In the absence of such policies and procedures in their respective facilities, clinicians can consult their facility’s legal or risk management departments. A lack of institutional policies that address consent and confidentiality for minors should not prevent clinicians from offering services that minors are legally allowed to access independently.

Education about and assistance with an insurance plan’s member services regarding the following rights is essential so adolescents are able to:

- Opt out of explanations of benefits or other communications (e.g., prior authorization notices) that are mailed to their parents or legal guardians regarding HIV care
- Request that insurance cards be mailed to the address of their choice (e.g., an alternate to family address)
- Ensure that information is not inadvertently disclosed through electronic portals that parents or legal guardians are able to access (see discussion in guideline section [New York State and Federal Law](#)).

Care providers are encouraged to provide hands-on assistance to adolescents when they need it to complete these tasks. Requirements vary across insurance companies and are not always straightforward. The NYSDOH [HIV Testing, Reporting and Confidentiality in New York State 2023 Update](#) provides information about minors’ confidentiality rights with insurance companies. See [NYSDOH HIV/AIDS Laws & Regulations](#) for information on laws pertaining to HIV testing, reporting, and confidentiality.

### → KEY POINT

- Coordination with insurance companies is necessary to ensure that confidentiality is managed according to the wishes of an adolescent patient.

## Good Practice Reminders and Resources

The following good practice reminders are for care providers who provide health services to adolescents in New York State:

- Stay up to date on New York State law regarding consent and confidentiality for adolescents.
- Ensure that adolescents <18 years old receive confidential care for HIV treatment and prevention.
- Educate adolescents who have or are at risk of HIV about the law and their rights.
- Inform adolescent patients about New York State reporting requirements (see NYSDOH HIV Reporting & Partner Services > [Five Things to Know About HIV/AIDS Reporting in New York State](#) and [NYSDOH Communicable Disease Reporting Requirements](#)).

- Ensure that institutional policies reflect New York State law regarding adolescents <18 years old who seek care for HIV treatment or prevention and who choose not to disclose this to their parents or legal guardians.
- Encourage adolescents who consent to their own care to identify an adult who can provide support.
- Make every effort to prevent disclosure of confidential information through release of medical records, pharmacy records, or explanation of benefits by creating clear policies and providing resources to help adolescent minors navigate the complexities of the healthcare system.

#### ◊ RESOURCES

- **NYSDOH AI:**
  - [Sexually Transmitted Infections Fact Sheets](#)
  - [Sexual Health Campaign](#)
  - [Sexual Health Plan](#)
- **Legal Action Center:** [Help with legal policy for people with criminal records, substance use disorders, and HIV or AIDS](#)
- **New York Civil Liberties Union:** [Teenagers, Health Care, and the Law: A Guide to Minors’ Rights in New York State](#)
- **CEI Line:** [Clinical Inquiry for HIV, HCV, STD, PEP, PrEP](#) • Toll-free: 1-866-637-2342

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# Supplement: Guideline Development and Recommendation Ratings

**Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program**

<b>Developer</b>	<a href="#">New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program</a>
<b>Funding source</b>	NYSDOH AI
<b>Program manager</b>	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See <a href="#">Program Leadership and Staff</a> .
<b>Mission</b>	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
<b>Expert committees</b>	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
<b>Committee structure</b>	<ul style="list-style-type: none"> <li>• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor</li> <li>• Contributing members</li> <li>• Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders</li> </ul>
<b>Disclosure and management of conflicts of interest</b>	<ul style="list-style-type: none"> <li>• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation.</li> <li>• The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.</li> </ul>
<b>Evidence collection and review</b>	<ul style="list-style-type: none"> <li>• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update.</li> <li>• A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations.</li> <li>• A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years.</li> <li>• Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.</li> </ul>
<b>Recommendation development</b>	<ul style="list-style-type: none"> <li>• The lead author drafts recommendations to address the defined scope of the guideline based on available published data.</li> <li>• Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations.</li> <li>• When published data are not available, support for a recommendation may be based on the committee’s expert opinion.</li> <li>• The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.</li> </ul>

**Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program**

<b>Review and approval process</b>	<ul style="list-style-type: none"> <li>• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee.</li> <li>• Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations.</li> <li>• Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.</li> </ul>
<b>External reviews</b>	<ul style="list-style-type: none"> <li>• External review of each guideline is invited at the developer’s discretion.</li> <li>• External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.</li> </ul>
<b>Update process</b>	<ul style="list-style-type: none"> <li>• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations.</li> <li>• If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.</li> </ul>

**Table S2: Recommendation Ratings and Definitions**

Strength	Quality of Evidence
A: Strong B: Moderate C: Optional	1      Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*      Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2      Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2 <sup>†</sup> Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3      Based on committee expert opinion, with rationale provided in the guideline text.