Medical Privacy in Dependency Cases: An Exploration of Medical Information Sharing in the Foster Care System

Brittany Strandell

Introduction

Kayla Smith2 is an eight-year-old girl who has recently entered foster care. The local child protective services agency ("CPS")3 investigated Kayla's living situation after receiving a report of abuse and neglect. After finding substantial evidence of physical, emotional and educational neglect, the court removed Kayla from her mother's care. Kayla's mother, Cheryl, battles a severe addiction to alcohol, which impairs her ability to care for Kayla.4 The current and primary goal for Kayla is reunification with her mother; however, the caseworker has concerns regarding Cheryl's addiction and financial

1 Brittany Strandell is an Associate at Conrad O'Brien, representing companies and individuals in a variety of commercial litigation matters. She obtained her J.D. from the University of Pennsylvania, where she was selected as an Alan Lerner Fellow in Child Welfare Policy.
2 Kayla Smith and her case are purely hypothetical.
3 Due to variations in state and county naming conventions for child welfare agencies, for the purposes of this paper, CPS refers to the state or county social services agency designated to investigate child abuse and to protect children's welfare.
4 See Christine Walsh, Harriet L. MacMillan, & Ellen Jamieson, The Relationship Between Parental Substance Abuse and Child Maltreatment: Findings from the Ontario Health Supplement, 27 CHILD ABUSE & NEGLECT 1409, 1409-1425 (2003) (investigating relationship between reported child abuse and parental history of substance abuse). "Parental substance abuse is associated with a more than twofold increase in the risk of exposure to both childhood physical and sexual abuse." Id. See also Isabel Wolock & Stephan Magura, Parental Substance Abuse as a Predictor of Child Maltreatment Re-Reports, 20 CHILD ABUSE & NEGLECT 1183, 1183-93 (1996). "It appears that among these cases closed after investigation, parental substance abuse does greatly increase the likelihood of poorer family functioning and re-reports for maltreatment to the CPS agency—both directly and as mediated by family functioning." Id. See also Richard Famularo, Robert Kinscherff, and Terence Fenton, Parental Substance Abuse and the Nature of Child Maltreatment, 16 CHILD ABUSE & NEGLECT 475, 475-83 (1992). "The results presented [in this study] are consistent with those of earlier studies in finding a strong relationship between substance abuse and child maltreatment. Of the 190 cases of maltreatment reviewed here, two thirds involved parents who abused substances." Id.
stability. Due to her mental state, financial problems and housing instability, Cheryl is difficult to contact.

Shortly after arriving at her foster home, Kayla experiences troubling symptoms in the middle of the night: shortness of breath, coughing, and wheezing when she inhales and exhales, and difficulty in catching her breath. These symptoms are the telltale signs of an asthma attack. Kayla’s foster care providers, however, are unaware of Kayla’s condition, and they are unfamiliar with the disease. The foster care providers rush Kayla to a local physician. In the doctor’s office, Kayla’s caregivers face their first legal barrier in treating Kayla’s asthma attack—consent to treatment. Since Kayla’s condition rises to that of an emergency,7 some of the finer distinctions are not analyzed, such as if Kayla is under a voluntary or involuntary placement agreement,8 if she requires routine versus non-routine care,9 whether

5 See Neal Halfon, Ana Mendonca, & Gale Berkowitz, Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child, 149 ARCHIVES OF PEDIATRICS & ADOLESCENT MEDICINE 386, 389 (1995). “Recurrent ear infections, congenital infections, mild neurological disorders, asthma, gastroesophageal reflux, enuresis, and ecopresis were common problems among children in the [Foster Care Program]. Asthma was diagnosed in 16.0% of all children, with the highest prevalence (22%) in toddlers (aged 13 to 36 months).” Id. Asthma is a common chronic illness among children in foster care. Id. See also Susan Cosgrove, Carlton Frist, Rebecca Chown, & Tawsif Anam, Strengthening Health Outcomes for Foster Care Children, WISCONSIN DEPARTMENT OF HEALTH SERVICES & WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES 8 (2013), http://www.lafollette.wisc.edu/images/publications/workshops/2013-DCF-DHS.pdf. “Common chronic childhood illnesses include asthma, diabetes, cystic fibrosis, malnutrition, developmental disabilities, autism, and other mental illnesses.” Id. See also Paul Tough, The Poverty Clinic: Can a Stressful Childhood Make You a Sick Adult? NEW YORKER 25, 26 (2011) (noting that certain conditions such as asthma and obesity have “particularly plagued poor children”); Ann S. Botash, FOSTER CARE: Health Concerns of Children in Foster Care, CHILD ABUSE EVALUATION & TREATMENT, http://www.childabusemd.com/foster/health-concerns.shtml (last visited March 27, 2015) (noting that asthma is possible medical problem of children in foster care).

6 See infra notes 51-52 and accompanying text (detailing medical consent for children in foster care).

7 See, e.g., 55 PA. CODE § 3130.91(3) (2014). “If the child requires emergency treatment . . . it is not necessary to obtain or provide consent when, in the physician’s judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the child’s life or health.” Id.

8 See generally 55 PA. CODE § 3130.91 (2014). For example, under the county agency must first consider whether the child is under a voluntary or involuntary placement agreement. Id. Where the placement agreement is voluntary, the county agency must obtain parental consent for all routine and non-routine treatments. Id. If the parent refuses to consent or if the parent cannot be located, then the county caseworker must obtain a court order. Id. Where the placement agreement is involuntary, the county agency may authorize routine treatment, but the agency must obtain parental consent for non-routine treatment. Id. If the parent cannot be located or is noncompliant, the agency must obtain a court order before proceeding with treatment. Id.

9 See, e.g., 55 PA. CODE § 3130.91(1)(i)–(ii) (2014) (providing examples of routine treatment). Id. For example, “well baby visits, immunizations and treatment for ordinary illnesses” and examples
the foster care providers are authorized to give consent, and whether Kayla's age requires her to actively consent to the services sought. The aforementioned issues, however, lurk under the surface of the State's child welfare system, which regulates the actors in the foster care system.

The next troubling legal issue presented is the lack of information on Kayla's medical history. Neither the childcare providers nor the treating physician is knowledgeable about Kayla's asthma history. Since symptoms of asthma are similar to other pulmonary conditions, the physician must try to determine the cause of her illness. This task is made more difficult because the physician's usual source of information about the child's health—Kayla's parent or guardian—in this case know nothing about Kayla's medical history. Even if the physician correctly diagnoses Kayla's asthma, the diagnosis only provides a piece of the puzzle. Asthma, like other chronic illnesses, comes in varying types and varies in severity. Additionally, the triggers for the disease, such as allergies, physical exertion, stress, or an underlying infection, depend on the patient. Treatment is yet another concern: Prior to removal from her home, did Kayla take medications for her illness? If so, what types of medication did Kayla take? What treatments does she best respond to without adverse side effects? Is she allergic to any medication? Does she have any comorbid diseases? A physician can often find the answers to these questions in the child's medical record; however, federal and state laws can create substantial barriers to gaining access to Kayla's medical record.

of non-routine treatment (e.g., "nonemergency cosmetic surgery, cosmetic surgery and experimental procedures or treatment"). The distinction between routine and non-routine care is vague. For instance, in Pennsylvania, the applicable laws never concretely define routine and non-routine treatment. Contra 110 MASS. CODE REGS. § 11.04 (2014) (defining "routine medical care").

See supra notes 8-9 and accompanying text (noting that authorization may vary depending on state law and county agency regulations).

See, e.g., 55 PA. CODE § 3130.91(5) (2015). [A] child who is 14 years of age or older shall consent to mental health treatment . . . . If a child refuses to give consent, a court order for involuntary treatment shall be obtained . . . . The consent of the parent or legal custodian is not valid in these instances.

Id.


Along with trying to determine the best course of treatment, there is the issue of teaching Kayla's current foster care providers how to care for an asthmatic child. This issue presents itself with an alarming frequency in the foster care setting because placements are rarely permanent. The average child in the system has three different foster care placements, and some children endure twenty to thirty placements during their childhoods. These new placements mean not only changes in caregivers but also potential changes in medical providers and CPS agencies. Without a fluid system that allows for integrated medical information sharing in the child welfare setting, the Kays of the world may struggle to maintain health care that is both continuous and effective.

This paper examines the current state of medical information sharing in dependency cases. Particular attention is given to the potential barriers to information sharing in this context and how these barriers could be altered. Part I explores the dependency court proceedings and interested parties with some detail. For the purposes of this paper, the term “dependency court” refers to the state court which hears cases involving child neglect or abuse. Part II examines the federal and state laws regulating the use of health information. Part III considers several solutions that could overcome


16 See Ashley Roads-Courter, Vulnerable Foster Children are Left Swinging from Home to Home, SEATTLE TIMES (March 5, 2015 5:20 PM), http://www.seattletimes.com/opinion/vulnerable-foster-children-are-left-swinging-from-home-to-home/ (citing one example of multiple foster home placements); Pam Fessler, Foster Kids Face Tough Times After Age 18, NPR (Apr. 7, 2010), http://www.npr.org/templates/story/story.php?storyId=125594259 (listing one example of a foster child spending time in 14 group homes).


18 See Facts on Foster Care in America, supra note 17. “Children have on average three different foster care placements. Frequent moves in and out of the homes of strangers can be profoundly unsettling for children, and it is not uncommon to hear of children who have been in 20 to 30 different homes.” Id. See also Roads-Courter, supra note 16 (citing one example of foster child spending time in twelve placements); Amy Fessler, Foster Kids Face Tough Times After Age 18, NPR, http://www.npr.org/templates/story/story.php?storyId=125594259 (listing one example of a foster child spending time in 14 group homes).
barriers to medical information sharing. Specifically, this paper concludes that states should create or refine laws pertaining to medical information sharing in dependency proceedings.

I. Dependency Court

According to the most recent Adoption and Foster Care Analysis and Reporting System ("AFCARS") Report, the number of children in foster care numbered 402,378. In 2013, approximately 254,904 children entered foster care, and an estimated 238,280 children exited the foster care system. Of the 402,378 children in foster care, only 101,840 children are waiting to be adopted. Nationally, 1,837,326 reports of child abuse were made in 2013. With fifty states reporting, an estimated 1,520 children died from child abuse in 2013.

As these numbers suggest, the stakes are high for the children in the child welfare system. If the CPS agency and the court do not remove a child from a dangerous environment, the child may suffer abuse and neglect or even death. If the

---

20 Id.
21 Id.
22 U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN AND FAMILIES, ADMIN. ON CHILDREN, YOUTH AND FAMILIES, & CHILDREN'S BUREAU, CHILD MALTREATMENT 2013 5--12 (2013). The report makes a distinction between “referrals” and “reports.” Id. at 6. Referrals pertain to “an initial notification . . . alleging child maltreatment.” Id. “Referrals that do not meet agency criteria are screened out or diverted from CPS to other community agencies.” Id. at 115. The referrals that are “screened-in” are called “reports.” Id. at 114. CPS agencies respond to reports; the response may be in the form of an investigation or an alternative response. Id. In 2013, the total number of referrals, including screened-in reports and screened-out referrals, was 3,016,794. U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN AND FAMILIES, ADMIN. ON CHILDREN, YOUTH AND FAMILIES, & CHILDREN'S BUREAU, CHILD MALTREATMENT 2013 12 (2014).
23 Id. at 54--63. “For FFY 2013, a nationally estimated 1,520 children died from abuse and neglect at a rate of 2.40 per 100,000 children in the population.” Id. at 54.
24 See, e.g., Jennifer McKim, Savage Toll of Abuse in DCF Care, THE BOSTON GLOBE, Feb. 2, 2014, available at http://www.bostonglobe.com/metro/2014/02/02/massachusetts-children-under-state-protection-die-from-abuse-with-alarming-frequency/2TcwcpIbWnrANkKKQs1CVP/story.html (discussing likelihood of Bay State children to die from maltreatment). Massachusetts estimates that children who received services from DCF in 2010 were about six times as likely as the general population of Bay State Children to die from maltreatment. Id. A tragic example is the case of Jeremiah Oliver, who police discovered at the side of a highway in
court mistakenly removes a child from his or her parent and declares the child dependent, the child may linger in the foster care system for months or years, moving from placement to placement, and may never achieve reunification with his or her natural parents. This section begins with an outline of the actors in the child welfare system. The paper then provides a brief overview of the dependency court system and its goals.

A. Identifying the Parties to a Juvenile Dependency Proceeding

For the purposes of this paper, the terms “dependency court” and “dependency proceeding” refer to the judicial proceeding whereby the court determines whether there is sufficient evidence of abuse or neglect to remove the child from the care of his or her parent or guardian. Some of the major actors in the dependency proceeding include the child, the child advocate, the parent, the CPS agency, and the foster provider. Pertinent state law grants these actors different roles, powers and obligations.

1. The Child

The average child in foster care in the United States is approximately nine years old, male, and likely identifies as a racial minority. Upon entering the child welfare system, Central Massachusetts. Id. See also Patricia Wen, The Short, Unhappy Life of Jeremiah Oliver, Failed by All, THE BOSTON GLOBE, May 15, 2014, available at http://www.bostonglobe.com/metro/2014/04/19/body-found-highway-was-missing-fitchburg-boy-jeremiah-oliver-authorities-say/HDD5vQsklUaWjdOhF7FHvO/story.html. Jeremiah Oliver’s lifeless body was discovered in a suitcase on the side of the road. Id. It was revealed that state social workers skipped eight mandatory monthly visits with Jeremiah, overlapping the time he disappeared. Id. However, even when social workers visited his family, they failed to pick up on signs that Oliver’s mother’s mental state was rapidly deteriorating, and that Jeremiah and his siblings were often hungry and in harm’s way. Id.


26 See infra Part I.A.1-5 (discussing specific role of each actor in dependency proceeding).

27 U.S. DEP’T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN AND FAMILIES, ADMIN. ON CHILDREN, YOUTH AND FAMILIES, & CHILDREN’S BUREAU, THE AFCARS REPORT NO. 21: PRELIMINARY FY 2013 ESTIMATES AS OF JULY 2014 (2014), available at http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport21.pdf (indicating that mean age of child in foster care is 8.9 and median age is 8.2). Id. According to the report, males comprise 52% of children in foster care while females comprise 48%. Id. The report also indicates the following racial/ethnic breakdown: American Indian/Alaskan Native—2%, Asian—1%, Black or African American—24%, Hispanic (of any race)—22%, White—42%, unknown—3%, two or more races—6%). Id. at 2.

A quarter of the children [in foster care] have health problems, and their
system, the average child is between the ages of seven and eight years old.\textsuperscript{28} The child spends approximately twenty-two months in care.\textsuperscript{29} The most frequent placement setting is a foster family home of a non-relative,\textsuperscript{30} and reunification with parents is the most common case plan goal for the child.\textsuperscript{31} Compared to children who are not in overall cognitive and social development lags slightly behind their peers. They are particularly at risk . . . of their social skills . . . A sizeable majority of the children fall substantially behind what might be expected for someone their age in at least one of the areas of well-being measured.


\textsuperscript{29} Id. (reporting mean time in care of 21.8 months and median time in care of 12.8 months).

\textsuperscript{30} Id. at 1 (noting 47% of children in foster care are residing at a non-relative foster family home).

\textsuperscript{31} Id. at 1 (noting other case plan goals include: living with relatives, adoption, long term foster care, guardianship). In the foster care system, “states and localities use relatives in a variety of ways to create permanency for children including as licensed foster care placements, informal placements, legal guardians, adoption, and some local communities recognize placement with a relative as reunification.” See also WESTAT CHAPIN HALL CTR. FOR CHILDREN, HHS, ASSESSING THE CONTEXT OF PERMANENCY AND REUNIFICATION IN THE FOSTER CARE SYSTEM CH. 2 PERMANENCY: A BALANCING ACT (2001). “Identifying and relying on kin for placements early can divert children from foster care, but at the same time may also lessen the use of services necessary to alleviate problems between birth parents and their children, leaving little chance for reunification.” Id.

Adoption is commanding a great deal of worker time and public money. There is a good deal of discussion about the expansion of adoption and how that has prompted the need for adoption expertise, increased adoptive services and larger adoption units, and budget changes to address these adoption needs. States have found it difficult to find an adequate pool of adoptive parents to meet the needs of children freed for adoption. Changes are ongoing in states focusing on recruiting an increased number of adoptive parents (to meet the increasing numbers of children waiting), using foster families as adoptive homes, broadening the geographic area for adoption home consideration, and promoting adoption through web sites . . .

. . . Guardianship has also become a popular permanency option. Id. Guardianship placement can mean many different things — placement with relatives or non-relatives, subsidized or unsubsidized placement. Id. Guardianship provides states an additional avenue to move children out of state custody. Id. Many states have implemented some type of guardianship option and
foster care, children in the foster care setting suffer from more physical and psychological illnesses.\textsuperscript{32}

In terms of health statistics, Laurel K. Leslie, testifying on behalf of the American Academy of Pediatrics, provided the following testimony to the House Ways and Means Subcommittee on Income Security and Family Support:

On any given day, approximately 540,000 children are in foster care, most of whom have been placed there as a result of abuse or neglect at home. Several decades of research has firmly established that the health care needs of children in out-of-home care far exceed those of other children living in poverty. Compared with children from the same socioeconomic background, children in foster care have much higher rates of birth defects, chronic physical disabilities, developmental delays, serious emotional and behavioral problems, and poor school achievement. In fact, nearly half of all children in foster care have chronic medical problems, about half of children ages 0–5 years in foster care have developmental delays, and up to 80% of all children in foster care have serious emotional problems.\textsuperscript{33}

2. Child Advocates

Under the Child Abuse Prevention and Treatment Act\textsuperscript{34} (hereinafter “CAPTA”), children are entitled to a guardian ad litem (hereinafter “GAL”).\textsuperscript{35} A GAL “may be an attorney or a court appointed special advocate who has received training others have plans to institute guardianship soon. States are quickly realizing the benefits of guardians and are using state funds (or using federal waiver money) to institute financial support to promote guardianship placements. Id.


\textsuperscript{35} 42 U.S.C. § 5106a(b)(2)(B)(xiii) (requiring GAL with appropriate training be appointed to represent child victims of abuse or neglect). \textit{See also} Judge Leonard Edwards, Representation of Parents and Children in Abuse and Neglect Cases: The Importance of Early Appointment, 63 JUVENILE AND FAMILY COURT JOURNAL 21, 21–22 (2012) (noting that “some states supplemented the federal law with statutes mandating legal representation for children”).
According to CAPTA, the GAL's duty is to represent the child during the dependency proceedings. To accomplish this goal, CAPTA instructs the GAL to "obtain first-hand, a clear understanding of the situation and the needs of a child; and "to make recommendations to the court concerning the best interests of the child." States, however, are free to supplement these basic requirements. For

---

36 42 U.S.C. § 5106a(b)(2)(B)(xiii). Training appropriate for the GAL role includes training related to early childhood, child and adolescent development. Id.

37 Id. See also Edwards supra note 35, at 24.

Children have a federal statutory right to a GAL in child abuse cases, and some states' statutes provide children the right to representation by an attorney. Some states require the GAL must be an attorney, while in others the GAL need only be a trained volunteer, often with the assistance of counsel, if necessary.

Id.


39 See Cynthia Grover Hastings, Note, Letting Down Their Guard: What Guardians Ad Litem should Know about Domestic Violence in Child Custody Disputes, 24 B.C. THIRD WORLD L.J. 283 (2004). “Each state, however, has vastly different requirements as to whom may be appointed, under what circumstances, and what the appropriate role of that person should be.” Id. at 293. See, e.g., Duties of Guardian Ad Litem, Pa. R.J.C.P. No. 1154 (2011). In Pennsylvania, the applicable law articulates nine duties:

1) Meet with the child as soon as possible following assignment pursuant to Rule 1151 and on a regular basis thereafter in a manner appropriate to the child's age and maturity;

2) On a timely basis, be given access to relevant court and county agency records, reports of examination of the guardians or the child, and medical, psychological, and school records;

3) Participate in all proceedings, including hearings before masters, and administrative hearings and reviews to the degree necessary to adequately represent the child;

4) Conduct such further investigation necessary to ascertain the facts;

5) Interview potential witnesses, including the child's guardians, caretakers, and foster parents, examine and cross-examine witnesses, and present witnesses and evidence necessary to protect the best interests of the child;

6) At the earliest possible date, be advised by the county agency having legal custody of the child of: (a) any plan to relocate the child or modify custody or visitation arrangements, including the reasons, prior to the relocation or change in custody or visitation; and (b) any proceeding, investigation, or hearing under the Child Protective Services Law, 23 Pa.C.S. § 6301 et seq. or
instance, Pennsylvania grants GALs access to all files and records that are in the possession of schools, police departments, hospitals and social service agencies. Furthermore, Pennsylvania grants the GAL the ability to “see and speak with the child, and family, medical and/or social service providers connected with [the] case . . . .” Access to the aforementioned providers, files, and records likely allows the GAL to assess actions that are in the child’s best interest.

3. Parents

Among parental factors associated with child maltreatment are: (1) certain factors

the Juvenile Act, 42 Pa.C.S. § 6301 et seq., directly affecting the child;
7) Make any specific recommendations to the court relating to the appropriateness and safety of the child’s placement and services necessary to address the child’s needs and safety, including the child’s educational, health care, and disability needs;
8) Explain the proceedings to the child to the extent appropriate given the child’s age, mental condition, and emotional condition; and
9) Advise the court of the child’s wishes to the extent that they can be ascertained and present to the court whatever evidence exists to support the child’s wishes. When appropriate because of the age or mental and emotional condition of the child, determine to the fullest extent possible the wishes of the child and communicate this information to the court.


PA.R.C.P. No. 1915.21 (reflecting order appointing GAL and authorization to provide GAL with records, reports and other information).

These files/records may include but are not limited to medical, psychological or psychiatric charts including evaluations and progress notes and records, X-rays, photographs, tests, test evaluations, intake and discharge summaries, police records, and school records including report cards, educational assessments and educational plans, relevant to this custody dispute and/or relevant to any special needs or requirements of the child. The guardian ad litem shall have the right to copy any part of the files and records maintained in connection with the child.

Id.

Id. (discussing order appointing a GAL in child custody action).
personality characteristics, such as psychological disorders; (2) parental history of abuse; (3) substance abuse; (4) attitudes and knowledge; and (5) caretaker age, particularly where the mother was young when she gave birth. Family factors associated with child maltreatment include marital conflict, poverty, single parenthood, and domestic abuse.

Unlike children, who are guaranteed some form of representation, parents may struggle to access adequate representation during the dependency proceedings. There is substantial variation by state in terms of parental representation:

Many state legislatures provide attorneys for parents in abuse and neglect cases, while some states provide for only discretionary appointment. In others, the appointment occurs late in the case at the adjudicatory or termination of parent rights hearing.

While reunification is the most common goal for children in foster care, parental rights can vary depending on state law and what the court in dependency proceedings have determined to be in the best interests of the child. In some

42 J. Goldman et al., U.S. DEP'T OF HEALTH & HUMAN SERVICES ADMIN. FOR CHILDREN & FAMILIES ADMIN. ON CHILDREN, YOUTH & FAMILIES CHILDREN'S BUREAU OFFICE ON CHILD ABUSE & NEGLECT, A COORDINATED RESPONSE TO CHILD ABUSE AND NEGLECT: THE FOUNDATION FOR PRACTICE 27-34 (2003). Some characteristics frequently identified in those who are physically abusive or neglectful include “low self-esteem, an external locus of control ... poor impulse control, depression, anxiety, and antisocial behavior.” Id. at 28.

43 Id. Negative attitudes and attributions about a child’s behavior and inaccurate knowledge about child development may play a contributing role in child maltreatment.” Id. at 29.

44 Id.

45 Id.


47 Judge Leonard Edwards (ret.), Representation of Parents and Children in Abuse and Neglect Cases: The Importance of Early Appointment, 63 JUV. & FAM. Ct. J. 21, 21 (2012) (discussing various scenarios in which children and parents are represented in abuse and neglect cases).

48 See supra note 31 (describing long term goals for children in foster care).

instances, the state permits the child to remain under the parent’s physical care, and the CPS agency monitors the parent-child interaction to ensure the placement is safe for the child.\textsuperscript{50} In other instances, the state removes the child from the parent, and the parent must cooperate with the court and the social service agency in order to regain custody of the child.\textsuperscript{51}

States also vary in terms of granting medical consent and granting access to a child’s records. Some states require parental consent for all non-emergency treatment,\textsuperscript{52} the best interest of a child, “Family Code section 3020, subdivision (a) declares that ‘the health, safety, and welfare of children shall be the court’s primary concern . . . .’” Id. at 1097. The Court must first evaluate the parents, then it can consider other options, like a non-parent, if the parent(s) is not in the best interest of the child. Id. The Court must consider “‘all factors relating to the best interest of the child,’ which would include the circumstances leading to guardianship, the parent’s efforts to maintain contact with the child, any exigencies that might hamper those efforts, and other evidence of commitment to parental responsibilities.” Id. at 1104.


\textsuperscript{52} See, e.g., Foster Parent Handbook, IOWA DEPT. HUM. SERVICES 43 (June 2002), available at https://dhs.iowa.gov/sites/default/files/comm33.pdf (requiring parental consent for non-emergency care). See also ALASKA STAT. § 47.10.084 (2014). The Alaska Statute for legal custody is as follows:

(a) When a child is committed under AS 47.10.080 (c)(1) to the department, released under AS 47.10.080 (c)(2) to the child's parents, guardian, or other suitable person, or committed to the department or to a legally appointed guardian of the person of the child under AS 47.10.080(c)(3), a relationship of legal custody exists. This relationship imposes on the department and its authorized agents or the parents, guardian, or other suitable person the responsibility of physical care and control of the child, the determination of where and with whom the child shall live, the right and duty to protect,
while other states allow foster providers or the CPS agency to provide consent for routine care. Additionally, some states grant parents control over certain protected health information, while still other states permit the CPS access to the child’s entire medical information.

4. Child Protective Services

According to the National Association of Public Child Welfare Administration, the local CPS agency’s mission should include the following responsibilities: (1) the agency is responsible for assessing the safety of children under its jurisdiction; (2) the agency must intervene where necessary to protect children from maltreatment; (3) the agency is responsible for strengthening families “ability to protect their children,” and, (4) the agency is responsible for providing a permanency plan for the child. In a nurture, train, and discipline the child, the duty of providing the child with food, shelter, education, and medical care, and the right and responsibility to make decisions of financial significance concerning the child. These obligations are subject to any residual parental rights and responsibilities and rights and responsibilities of a guardian if one has been appointed. When a child is committed to the department and the department places the child with the child’s parent, the parent has the responsibility to provide and pay for food, shelter, education, and medical care for the child. When parental rights have been terminated, or there are no living parents and no guardian has been appointed, the responsibilities of legal custody include those in (b) and (c) of this section. The department or person having legal custody of the child may delegate any of the responsibilities under this section, except authority to consent to marriage, adoption, and military enlistment may not be delegated. For purposes of this chapter, a person in charge of a placement setting is an agent of the department.

Id.

53 See, e.g., ALASKA STAT. § 47.10.080 (2014) (explaining who can grant medical consent for a child in state custody); 55 PA. CODE § 3130.91 (2015) (permitting county agencies to grant medical consent for routine care).


55 See, e.g., The MISSOURI DEPARTMENT OF SOCIAL SERVICES, CHILD WELFARE MANUAL § 4, ch. 24 (detailing how Missouri grants their social services access to all medical records). Id. See also ILLINOIS DEPARTMENT OF HUM. SERV’S., § 10.3: MEDICAL RECORDS, available at https://www.dhs.state.il.us/page.aspx?item=40657 (noting family clinics must retain all records, documents, correspondence relative to medical services).

56 D. DePANFILIS, & M. K. SALUS, CHILD PROTECTIVE SERVICES: A GUIDE FOR CASEWORKERS
general sense, the process can be reduced to a seven-stage process.\textsuperscript{57} The first two stages include evaluating and investigating child maltreatment reports.\textsuperscript{58} In cases where the reports of child maltreatment have been substantiated, the agency’s primary concern becomes securing the child’s safety.\textsuperscript{59} In the third stage, a caseworker conducts a family assessment; the purpose of this assessment is to determine the family’s particular strengths and weaknesses.\textsuperscript{60} For the fourth stage, the caseworker develops three types of plans—a safety plan, a case plan, and a permanency plan.\textsuperscript{61} The safety plan is developed “whenever it is determined that the child is at risk of imminent harm.”\textsuperscript{62} The case plan includes observations from the family assessment, and it describes goals and outcomes.\textsuperscript{63} The permanency plan contemplates ways in which reunification can be accomplished and how permanency may be achieved where reunification is not

\begin{itemize}
  \item DePanfilis, supra note 56 at 7.
  \item Id. at 29-65.
  \item DePanfilis, supra note 56 at 69-75.
  \item \textit{Id.} at 77-82. When the case worker first meets the child and the family, they make a general assessment of the situation and determine the safety of the child. \textit{Id.} at 29. The criteria considered when assessing and creating a safety plan are “the level of severity of the incident or the harm to the child, the person responsible for the alleged abuse or neglect, and the family’s situation.” \textit{Id.} at 36. A case plan is developed with the family, and acts as a roadmap for successful intervention. \textit{Id.} at 77. The purpose of case planning is to address the maltreatment and identify strategies to change behavior and prevent future risk and harm. \textit{Id.} As far as the permanency plan, generally social workers are required to work up two concurrent plans; something for the immediate future to keep the child safe, and one that is a more permanent solution that can be put into place as soon as the family meets all the requirements. DePanfilis, \textit{supra} note 56 at 82. See also \textit{Case Management for Child Abuse, Neglect, and Dependency Guidebook}, \textit{NEB. DEP'T OF HEALTH AND HUMAN SERVS.}, (Dec. 2005) http://dhhs.ne.gov/children_family_services/Guidebooks/Case%20management%20for%20Child%20Abuse,%20Neglect%20and%20Dependency%20Guidebook.pdf (discussing permanency plans, including objectives and realistic timeline by which permanency should be obtained).
  \item DePanfilis, \textit{supra} note 56 at 77-79.
  \item \textit{Id.}
possible. In the fifth stage, the agency must coordinate recommended services for both children and families. The sixth stage requires an assessment of progress. The final step is case closure.

To perform these responsibilities in an effective manner, the Child Welfare League of America recommends that caseworkers be tasked with caseloads no more than twelve to fifteen children in foster care. In actuality, however, "[t]he average caseload for child welfare workers often exceeds recommended levels, sometimes by double or more."
Access to medical information is an important consideration when determining where and with whom to place a child, in conducting family assessment and goals, and when developing an effective case plan. States vary substantially on whether CPS agencies can access a child's pre-existing medical information. Where states have under-developed laws in this area or laws restricting the access of medical records, there is a risk that children entering foster care will fail to receive proper preventative medical care or care for already identified illnesses.

5. Foster Care Providers

Foster care providers come in different varieties. Federally, the term “foster care” is defined to mean “24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility.” Foster care providers are distinguished from “legal guardianship,” which refers to “[a] judicially-created relationship between child and caretaker which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decision-making.”

The most common type of foster placements include foster family homes, http://www.bostonglobe.com/metro/2014/07/08/dcf-chief-agency-has-hired-more-than-workers-will-distribute-ipads/8C2MQzSYnqw0gXleyVTH5O/story.html (noting in Massachusetts as of May 2014, “the state average was about 20 cases per worker”). See generally DePanfilis, supra note 56 (outlining various duties of CPS case workers). See, e.g., CHILD WELFARE MANUAL, MO. DEP'T OF SOC. SERVS., http://dss.mo.gov/cd/info/cwmanual/ (last visited March 29, 2015). Missouri grants their social service agency access to all medical records under Section 5, chapter 2, sub-section 2 of the state’s Department of Social Services and Child Welfare manual. Id.; 55 PA. CODE § 5100.33(a) (LexisNexis 2015). Pennsylvania requires parental consent to release PHI associated with certain kinds of medical care. Id.

The regulation defines “foster family home” as:

“[t]he home of an individual or family licensed or approved as meeting the standards established by the State licensing or approval authority (ies) . . . that provides 24-hour and out-of-home care for children. The term may include group homes, agency-operated boarding homes or other facilities licensed or approved for the purpose of providing foster care by the State agency responsible for approval or licensing of such facilities. Foster family homes that are approved must be held to the same standards as foster family homes that are licensed.”
kinship care,74 and institutional care.75 In order to provide adequate care, it seems prudent for foster care providers to have some information pertaining to the child’s medical history, given their primary, daily interactions with the child. State laws, however, vary with regard to medical consent and disclosure policies for foster care institutions.

74 Definitions and Language of Kinship Care, U.S. DEP’T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN AND FAMILIES, ADMIN. ON CHILDREN, YOUTH AND FAMILIES, & CHILDREN’S BUREAU, available at https://www.childwelfare.gov/topics/outofhome/kinship/about/definitions (last visited March 31, 2015). While the definition of kinship care will vary depending on the State, kinship care is often defined as “[t]he full-time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or other adults who have a family relationship to a child.” Id.

B. Timeliness & Permanence: Important Goals of Dependency Proceedings

An important purpose of the dependency court proceeding is achieving permanency for the child in a timely manner. Permanency may be achieved through parent-child reunification or through adoption; however, “the majority of children exiting foster care are reunified with their families, not adopted.” According to a Health and Human Services (“HHS”) report to Congress in 2012, “[a]cross states, the median percentage of reunifications occurring in less than 12 months was between 68.4 and 70.5 percent.” The adoption data, however, was less optimistic: “[I]t was unusual in most states for adoptions to occur in less than 12 months from the child’s entry into foster care. The national median . . . was only 3.8 percent.” Overall, the average child


78 Id. at 22. See also Determining the Best Interests of the Child, CHILD WELFARE INFORMATION GATEWAY - U.S. DEP’T OF HEALTH & HUMAN SERVS., available at https://www.childwelfare.gov/pubPDFs/best_interest.pdf?page=1&view=Introduction (last visited March 30, 2015) (noting importance of maintaining family integrity and preference for avoiding removal of child from home). But see Dashawn W., 992 N.E.2d 402, 407 (2013) (discussing child should not be reunified with parent because against best interests of child). “The judge therefore found that ‘efforts to encourage and strengthen the parental relationship would be detrimental to the best interests of [Jayquan] as they would consign him to a further protracted stay in foster care, thereby depriving him of permanency and of a normal, healthy and safe life, with virtually no likelihood of ultimate reunification.’” Id. at 407.


80 Id. at 23. Barriers to timely adoption include, for example, ensuring the child is legally free for adoption in that the biological parents’ rights have been terminated, and each state may have a different process. Id. Once the parental rights have been terminated, the state should work as
spends approximately twenty-three months in foster care. Eighty-one percent of children remain in the foster care system for five years or more.

C. The Process & Procedure of Dependency Court

A case in dependency court often begins with an allegation of child abuse or neglect. Depending on a state's child protective laws, the designated CPS agency may investigate the reported child maltreatment. If, after a preliminary investigation, the
agency determines that the child is in danger, the agency may take the child into emergency protective custody.\(^{85}\) Another way for children to enter the foster care system is if the parent voluntarily relinquishes his or her custody of the child to an appropriate entity.\(^{86}\) This cessation of custody may be permanent or temporary.\(^{87}\)

If the child is to stay under the court's jurisdiction, the agency must file a dependency petition, requesting that the court adjudicate the child dependent.\(^{88}\) At the adjudication hearing, the court will examine the merits of the petition.\(^{89}\) If the court adjudicates the child dependent, the court can order an in-home or an out-of-home placement for the child.\(^{90}\) If the court orders an out-of-home placement, under the Adoption and Safe Families Act\(^ {91} \) (hereinafter “ASFA”), a permanency plan hearing generally require the CPS agency to go to court and for the parents or caretakers to be notified as soon as the child is placed in foster care. \(\text{Id.}\)

\(^{85}\) See, e.g., MASS. GEN. LAWS ch. 119 § 23 (2015) (allowing DCF to place a child in emergency custody without a hearing); MASS. GEN. LAWS ch. 119 § 51B (2015) (describing DCF investigation and court procedures for removing child or restricting or terminating parent's rights).

\(^{86}\) MASS. GEN. LAWS ch. 119 § 23 (2015) (describing responsibilities of agency to child when that child's parents have no rights regarding child); MASS. GEN. LAWS ch. 210 § 3 (2015) (allowing DCF to move forward in adoption cases when parental rights are terminated); Juvenile Court Standing Order 1-10 Schedule Care and Protection and Termination of Parental Rights Trials, MASSACHUSETTS COURT SYSTEM (last visited March 25, 2015) (regulating length and purpose of trial terminating parental rights or involving abuse or neglect allegations); Paula Mackin, Prospective Parents and Adoption Agencies: The Need for Individual Representation of Massachusetts Adopters, 43 B.B.J. 8, 22 (1999) (explaining complications in adoption cases where parents previously terminated rights, but later changed their minds). \(\text{See generally Adoption of Willow & Others, 745 N.E.2d 636 (2001) (finding DCF's adoption goals were sufficient proof mother's parental rights terminated when she voluntarily surrendered children).}\)

\(^{87}\) See, e.g., MASS. GEN. LAWS ch. 119, § 23 (2015) (explaining parent can temporarily relinquish custodial rights).

\(^{88}\) See, e.g., PA.R.J.C.P. No. 1200. "A dependency petition is to be filed if a guardian requests return of the child and the county agency refuses to return the child." \(\text{Id.}\) The purpose of a dependency petition is to establish that a juvenile court has jurisdiction over a child. \(\text{See Hadley B. v. Cam B., 56 CAL. RPTR. 3d 234, 235 (Cal. Ct. App. 2007).} \) Examples of allegations that an agency can include in a dependency petition are neglect, failure to protect, abandonment, and abuse. \(\text{Id.}\)

\(^{89}\) See, e.g., PA.R.J.C.P. No. 1408 (2015). "After hearing the evidence on the petition ... the court shall enter a finding by specifying which, if any, allegations in the petition were proved by clear and convincing evidence." \(\text{Id.}\)

\(^{90}\) See, e.g., PA.R.J.C.P. No. 1409 (2015) (explaining court decides whether child is dependent of court or should return to home).

\(^{91}\) Pub. L. No. 105-89, 111 Stat. 2115 (1997). The stated goal of the Adoption and Safe Families Act is to "promote the adoption of children in foster care." \(\text{Id.}\) The Act lays out safety requirements for the foster care and adoption placement processes. \(\text{Id.}\)
must be held within a year of the child entering care and every year that the child remains in foster care. In addition to permanency hearings, ASFA further requires a court or an administrative entity to review the child’s status at least once every six months.

II. The Problem: Medical Information Sharing in Dependency Cases

As the introductory hypothetical illuminates, certain federal and state laws can present a barrier to effective and continuous treatment of children in foster care. The legal analysis for medical privacy concerns is somewhat simplified when the parent has complete custody over the child or when an adoptive entity has complete custody over the child. However, children who are subject to dependency proceedings occupy an uncomfortable middle ground where parental rights have not been terminated, but the parent, for the time being, does not have custody of the child.

A. The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (hereinafter “HIPAA”) was passed by the United States Congress with bipartisan support. At the time of its enactment, HIPAA was notable for the resulting changes made to the health

---

92 42 U.S.C.A. § 675(5)(C), P.L. 113-296 (LexisNexis 2015). The permanency plan hearing determines whether a child will return to the parent, be placed for adoption (the state will file for termination of parental rights in this case), be placed for legal guardianship, or be placed in “another planned permanent living arrangement.” Id.


94 See supra notes 7-11, 15 and accompanying text (highlighting legal barriers to treatment of foster care children).


insurance market. HIPAA provided protections for employees who may be dropped from their insurance plans. The Act prohibited pre-existing condition exclusions under specific circumstances.

B. An Overview of the Privacy Rule

At the time of HIPAA’s enactment, Congress had not yet articulated the law’s Privacy Rule. “Unable to agree on specific rules, Congress set a deadline for itself, 100

97 See Chaikind et al supra note 96 (noting HIPAA impact resulting in significant changes to health insurance market).
98 See id.

Under HIPAA, a plan is allowed to look back only 6 months for a condition that was present before the start of coverage in a group health plan. Specifically, the law says that a preexisting condition exclusion can be imposed on a condition only if medical advice, diagnosis, care, or treatment was recommended or received during the 6 months prior to your enrollment date in the plan. As an example, you may have had arthritis for many years before you came to your current job. If you did not have medical advice, diagnosis, care, or treatment—recommended or received—in the 6 months before you enrolled in the plan, then the prior condition cannot be subject to a preexisting condition exclusion. If you did receive medical advice, diagnosis, care, or treatment within the past 6 months, then the plan may impose a preexisting condition exclusion for that condition (arthritis). In addition, HIPAA prohibits plans from applying a preexisting condition exclusion to pregnancy, genetic information, and certain children.

If you have a preexisting condition that can be excluded from your plan coverage, then there is a limit to the preexisting condition exclusion period that can be applied. HIPAA limits the preexisting condition exclusion period for most people to 12 months (18 months if you enroll late), although some plans may have a shorter time period or none at all. In addition, some people with a history of prior health coverage will be able to reduce the exclusion period even further using "creditable coverage." Remember, a preexisting condition exclusion relates only to benefits for your (and your family's) preexisting conditions. If you enroll, you will receive coverage for the plan's other benefits during that time.

Id. See Focus on Health Care Reform, HENRY J. KAISER FAMILY FOUND., https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8356.pdf (discussing HIPAA and ACA in terms of pre-existing conditions).

100 See 45 C.F.R. §§ 164.501-164.534 (2004) (Privacy Rule incorporated in 2003 under HIPAA);
August 21, 1999, for enacting federal privacy standards, in lieu of which those standards were to be set by the secretary of Health and Human Services.”

Likely due to third-party interests, Congress did not set the privacy standards by its deadline, and Health and Human Services issued a proposed rule in 1999. Numerous public comments along with a change in presidential administrations delayed the Privacy Rule; HHS issued the final version of the rule in 2002. “Most health care providers and health plans were required to be in compliance with this version of the HIPAA Privacy Rule by April 14, 2003. Small health plans were given until April 14, 2004, to be in compliance.”

The Privacy Rule applies to the following entities: (1) health plans; (2) health care providers who transmit health information electronically; and (3) health care clearinghouses. The Privacy Rule protects certain types of information, protected health information ("PHI"), from disclosure. Protected health information refers to


101 PAUL STARR, REMEDY AND REACTION 140 (2011) (describing HIPAA established privacy provisions for health information exchanges, but not creating federal privacy standards).

102 See COMM. ON HEALTH RESEARCH AND THE PRIVACY OF HEALTH INFO.: THE HIPAA PRIVACY RULE ET. AL., BEYOND THE HIPAA PRIVACY RULE: ENHANCING PRIVACY, IMPROVING HEALTH THROUGH RESEARCH 64 (Sharyl J. Nass et. al., eds., 2009) (analyzing how public commentary had effect on timely execution of Privacy Rule). There was an enormous amount of comments received by Congress regarding the regulation. Id. See also HIPAA’s Long and Winding Road, HEALTH DATA MGMT. 2003 WLNR 158778, Feb. 28, 2003 (discussing how third-parties were unprepared for Privacy Rule incorporation). Few organizations were prepared to spend money on HIPAA compliance based on the proposed requirements. Id. Additionally, providers were skeptical about the cost-savings suggested to come with the enactment. Id. Furthermore, many businesses were more concerned with Y2K computer changeovers at this time. Id.

103 See COMM. ON HEALTH RESEARCH AND THE PRIVACY OF HEALTH INFO., supra note 102, at 64.

104 Id.

105 45 C.F.R. §§ 160.102 (outlining provision applicability of Privacy Rule).

106 45 C.F.R. § 160.103 (protectable information is defined under Privacy Rule). See What Health Information Is Protected by the Privacy Rule? THE NATIONAL INSTITUTE OF HEALTH, available at http://privacyruleandresearch.nih.gov/pr_07.asp (discussing exceptions to information covered
"individually identifiable health information" that is transmitted or maintained electronically or "in any other form or medium."\textsuperscript{107} Likewise, "individually identifiable health information" is defined as:

[a] subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearing house; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.\textsuperscript{108}

The designation "protected health information" does not include: (1) FERPA-covered educational records; (2) employment records; (3) information "regarding a person who has been deceased for more than 50 years;" or, (4) de-identified information.\textsuperscript{109}

\textsuperscript{107} 45 C.F.R. § 160.103 (defining protected health information, or "PHI").
\textsuperscript{108} Id. (explaining how "individual health information" is defined under § 160.103).
\textsuperscript{109} Family Educational Rights and Privacy Act of 1974 ("FERPA"), 20 U.S.C. § 1232g (2013) (giving parents access to and control over their children’s education records); 45 C.F.R. § 160.103 (June 27, 2014) (defining protected health information ("PHI"), including educational records under FERPA); 45 C.F.R. § 164.502 (March 26, 2013) (discussing appropriate uses of PHI, including for a deceased individual and de-identified information); 45 C.F.R. § 164.514 (June 7, 2013) (discussing permissible PHI uses, including employment records).
C. Disclosures

A covered entity is permitted to disclose PHI without an individual's prior authorization in the following instances: (1) to the individual; (2) for treatment, payment, and health care operations;\textsuperscript{110} (3) to provide the individual with the opportunity to agree or object; (4) where the disclosure is incident to an otherwise permitted use and disclosure; (5) for activities that benefit the public interest;\textsuperscript{111} (6) for limited data sets.\textsuperscript{112} Covered entities are required to disclose PHI in two instances: (1) when an individual requests the information; and (2) when HHS requires the PHI in order to investigate or determine the covered entity's compliance with HIPAA.\textsuperscript{113}

If a covered entity wishes to disclose PHI in a manner that the Privacy Rule does not list under its permitted or required disclosures, then the covered entity must obtain the individual's written consent in order to disclose the PHI.\textsuperscript{114}

\textsuperscript{110} 45 C.F.R. §§ 164.501, 164.502(a), 164.506 (March 26, 2013) (discussing permitted uses and disclosures for treatment, payment and health care operations ("TPO"). Treatment refers the "provision, coordination, or management of health care and related services among health care providers." Uses, and Disclosures for Treatment, Payment and Health Care Operations, U.S. DEP'T OF HEALTH & HUMAN SERVS., (Apr. 3, 2013), http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html. 'Payment' refers to providers attempt at reimbursement for providing services. Id. 'Health care operations' refers to "certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment." Id.

\textsuperscript{111} See Summary of the HIPAA Privacy Rule, U.S. DEP'T OF HEALTH & HUMAN SERVS. 6-7 (May 2003), http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf (summarizing types of activities that qualify as "public interest and benefit activities"). The activities include the following: (1) disclosures permitted or required by law; (2) disclosures that are determined to be public health activities; (3) disclosures related to victims of abuse, neglect, or domestic violence; (4) disclosures categorized as health oversight activities; (5) disclosures needed for judicial and administrative proceedings; (6) disclosures necessary for law enforcement purposes; (7) disclosures needed for decedents, funeral directors, coroners, or medical examiners; (8) disclosures needed for cadaveric organ, eye, or tissue donation; (9) disclosures necessary for research; (10) disclosures necessary to thwart a serious threat to health or safety; (11) disclosures needed to perform essential government functions; and (12) disclosures authorized workers' compensation. Id.

\textsuperscript{112} 45 C.F.R. § 164.514(e) (providing definition of limited data set as well as its implementation specifications). See also Summary of the HIPAA Privacy Rule, supra note 111, at 9. Limited data set is PHI that may be used for research, health care operations, and public health purposes so long as the recipient enters into a data use agreement prior to disclosure. Id.

\textsuperscript{113} 45 C.F.R. § 164.502(a)(2)(ii) (discussing when a covered entity is required to investigate or determine its compliance with HIPAA).

\textsuperscript{114} 45 C.F.R. § 164.508 (discussing when an individual's authorization for use and disclosure of PHI is statutorily required). See also U.S. DEP'T OF HEALTH & HUMAN SERVS., supra note 111, at 9-10 (discussing when an individual's written authorization is required).
authorization must be in writing and, like with all disclosures, the sharing of PHI must be limited to the minimum information necessary to complete the request.  

D. Preemption  

The Privacy Rule preempts state laws which impede or run contrary to the Privacy Rule.  

According to HHS, there are exceptions to the Privacy Rule:

The Privacy Rule provides exceptions to the general rule of federal preemption for contrary State laws that (1) relate to the privacy of individually identifiable health information and provide greater privacy protections or privacy rights with respect to such information, (2) provide for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention, or (3) require certain health plan reporting such as for management or financial audits.  

115 45 C.F.R. § 164.502(a)(1)(iii) (allowing use or disclosure of information incident to use or disclosure otherwise permitted by regulation). See also Incidental Uses and Disclosures, U.S. DEPT OF HEALTH & HUMAN SERVS., (Dec. 3, 2002), http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/incidentaluses.pdf (outlining Department of Health and Human Services Office for Civil Rights’ (“OCR”) guidance concerning regulations). Such use or disclosure is permitted provided that the covered entity has implemented safeguards and the minimum necessary standard. Id. at 1. The minimum necessary standard requires that covered entities implement policies and procedures to limit the use of and access to PHI. Id. at 2. It does not apply to disclosures. Id.  

116 45 C.F.R. § 160.203 (discussing the federal rule that preempts any contrary state law). See Grace Ko, Partial Preemption under the Health Insurance Portability and Accountability Act, 79 S. CAL. L. REV. 497 (2006) (discussing HIPAA’s partial preemption, including its scope, problems with implementation and judicial interpretation). The preemption provision states that HIPAA and its corresponding regulations preempt contrary state laws; however, it does not completely preempt all such laws. Id. at 501. Instead, individual provisions of state laws, regulations, common law and even city code must be examined to determine whether federal law preempts state law. Id. at 502-03, 507. “State law provisions that are more stringent will survive and reverse preempt the federal law, while those that are less stringent will be preempted.” Id. at 505. See, e.g., Martha Tucker Ayres, Confidentiality And Disclosure of Health Information in Arkansas, 64 ARK. L. REV. 969, 1017 (2011) (detailing Arkansas’ privacy rule, including in context of federal preemption). Arkansas’ privacy rule establishes a fifteen-dollar labor fee that providers can charge for copying medical records, whereas federal law states that a provider can only charge a “reasonable, cost-based fee.” Id. at 1017. The Arkansas law is broader because it covers requests by individuals and attorneys, whereas federal law applies only to individuals seeking copies of their own records. Id. It is plausible that a judge would rule that federal law preempts Arkansas law because it is more protective of individual rights with respect to requests for medical records. Id.  

117 U.S. DEPT OF HEALTH & HUMAN SERVS., supra note 111, at 17 (discussing state law and exceptions to general rule of federal preemption). See generally 45 C.F.R. § 160.203 (discussing federal rule that preempts contrary state law).
Additionally, HHS may determine that a state law is not preempted where it finds that the law is necessary: (1) "to prevent fraud and abuse related to the provision of or payment for health care;" (2) "to ensure appropriate State regulation of insurance and health plans;" (3) "for State reporting on health care delivery or costs;" or (4) "for purposes of serving a compelling public health, safety, or welfare need."

E. Enforcement & Penalties

The Department of Health and Human Services Office for Civil Rights ('OCR') may impose civil and criminal penalties and punishments on covered entities which fail to comply with the Privacy Rule's requirements. Civil penalties "vary significantly depending on factors such as the date of the violation, whether the covered entity knew or should have known of the failure to comply or whether the covered entity’s failure to comply was due to willful neglect." Civil penalties can range from $100 per violation to $50,000 or more per violation. The penalty's yearly cap can range from $25,000 to $1,500,000 depending on the date of the violation. OCR, however, will not impose penalties for violations if:

the failure to comply was not due to willful neglect, and was corrected during a 30-day period after the entity knew or should have known the failure to comply had

---

118 U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 111, at 17.
119 See id. at 17-18 (describing civil and criminal penalties for noncompliance). HHS may impose a civil penalty of a $100 fine for each compliance violation, up to $25,000 per year for each identical violation. Id. at 17. HHS may impose a criminal penalty a $50,000 fine and up to one-year imprisonment. Id. at 18. Additionally, criminal penalties may "increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm." Id.
121 See The Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. § 1320d–5(a)(3) (describing four tiers of penalties); 45 C.F.R § 160.404 (2014) (providing civil penalty amounts). The tiered system provides for fines based on the breaching party's culpability. See id. When an entity did not know and reasonably would not have known of the violation, the fines range from a minimum of $100 per violation to an annual maximum of $1.5 million. Id. When a violation is due to willful neglect and is not corrected, the penalty starts at $50,000 per violation and goes up to an annual maximum of $1.5 million. Id.
occurred [(unless the period is extended at the discretion of OCR)]; or the Department of Justice has imposed a criminal penalty for the failure to comply already.\textsuperscript{123}

Criminal penalties depend on the severity of the prohibited conduct and can range from $50,000 and one-year imprisonment to $250,000 and ten years imprisonment.\textsuperscript{124}

F. The Privacy Rule & Minors

Where an applicable state law designates, a parent, guardian, or individual acting in loco parentis\textsuperscript{125} has the authority to act as an unemancipated child's personal representative with regard to decisions related to the child's health care.\textsuperscript{126} The HIPAA covered entity must treat the personal representative as it would treat the individual who is the subject of the treatment "with respect to protected health information relevant to such personal representation."\textsuperscript{127} There are, however, several exceptions to this general

\textsuperscript{123} HIPAA Privacy, Security, Enforcement and Breach Notification Rules, supra note 120. See also 42 U.S.C. § 1320d–5(b) (providing specific limitations on civil penalty enforcement). The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), passed as part of the American Recovery and Reinvestment Act of 2009, significantly increased the civil penalties for violating the HIPAA rules. See Vadim Schick, After HITECH: HIPAA Revisions Mandate Stronger Privacy and Security Safeguards, 37 J.C. & U.L. 403, 404, 415-16 (2011) (discussing the increased penalties for unlawful PHI disclosures under HITECH compared to HIPAA).

\textsuperscript{124} See 42 U.S.C. § 1320d–6(b) (providing criminal penalty amounts).

\textsuperscript{125} See generally Niewiadomski v. U.S., 159 F.2d 683, 686 (6th Cir. 1947). In loco parentis "refers to a person who has put himself in the situation of a lawful parent by assuming the obligations incident to the parental relation without going through the formalities necessary to legal adoption. It embodies the two ideas of assuming the parental status and discharging the parental duties." Id. See also BLACK'S LAW DICTIONARY (10th ed. 2014). In loco parentis is defined as "[o]f, relating to, or acting as a temporary guardian or caretaker of a child, taking on all or some of the responsibilities of a parent." Id.


\textsuperscript{127} 45 C.F.R. §§ 164.502(g)(1), 164.502(g)(3)(i) (2014). According to the Privacy Rule, the authority of a personal representative:

\begin{quote}

derives from his or her authority under applicable law to make health care decisions for the individual. Where the person has broad authority to act on the behalf of a living individual in making decisions related to health care, such as is usually the case with a parent with respect to a minor child or a legal guardian of a mentally incompetent adult, the covered entity must treat the personal representative as the individual for all purposes under the Rule, unless an exception applies.
\end{quote}

rule. The first exception applies when the minor consents to the health care service and has not specified a personal representative. In the aforementioned instance, "no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained." The second exception applies where the "[m]inor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting in loco parentis." The third exception applies when "[a] parent, guardian, or other person acting in loco parentis assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service."

With regard to more specific disclosure provisions, the Privacy Rule largely defers to applicable state law:

(A) If, and to the extent, permitted or required by an applicable provision of State or other law, including 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;

(B) If, and to the extent, prohibited by an applicable provision of State or other law, including 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; and


128 45 C.F.R. §§ 164.502(g)(3)(i)(A)-(C) (2014). See Personal Representatives, supra note 127 (describing that minor health care information can be obtained without parental consent). The general purpose of the exceptions is to:

generally track the ability of certain minors to obtain specified health care without parental consent under State or other laws, or standards of professional practice. In these situations, the parent does not control the minor’s health care decisions, and thus under the Rule, does not control the protected health information related to that care.


130 Id.

131 Id. § 164.502(g)(3)(i)(B) (2014) (requiring generally consent of minor, court or other allowed for health services).

132 Id. § 164.502(g)(3)(i)(C) (2014).
(C) Where the parent, guardian, or other person acting in loco parentis, is not the personal representative ... and where there is no applicable access provision under State or other law, including case law, a covered entity may provide or deny access ... to a parent, guardian, or other person acting in loco parentis, if such action is consistent with State or other applicable law, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment.133

The Privacy Rule also contemplates disclosure issues in abuse, neglect, and endangerment situations.134 While the Privacy Rule openly defers to state law and procedure, the regulation allows a covered entity to refuse to treat someone as a child’s personal representative under two circumstances.135 First, a covered entity may refuse to treat an individual as a personal representative where the covered entity has a reasonable belief that the person has abused or neglected the child.136 The second circumstance when a covered entity may refuse to treat a person as a personal representative is if there is a reasonable belief that “[t]reating such person as the personal representative could endanger the individual.”137

The HIPAA Privacy Rule provides adequate guidance for the majority of cases where a parent is the child’s personal representative, allowing the parent to access their child’s medical records and to exercise other individual rights.138 By extension, when the child has been formally adopted, the issues surrounding consent and disclosure similarly

133 Id. §§ 164.502(g)(3)(ii)(A)–(C).

These uses and disclosures include those required by law, for public health activities, when abuse, neglect, or domestic violence is involved, for health oversight activities, for judicial and administrative proceedings, for law enforcement purposes, to funeral directors, to facilitate the donation of organs and tissue, for research, to prevent a serious threat to health or safety, when required by essential government functions, and for worker’s compensation matters.

Id.
135 45 C.F.R. § 164.502(g)(5)(i).
136 45 C.F.R. § 164.502(g)(5)(i)(A).
137 45 C.F.R. § 164.502(g)(5)(i)(B).
138 See infra note 140 and accompanying text (illustrating parental access to minor child medical records is dependent on state law).
When parental rights are disputed, the Privacy Rule ‘defers to State or other applicable laws that expressly address the ability of the parent to obtain health information about the minor child.’ Where state law is silent on matters pertaining to parental access to the minor’s health information, “[a] covered entity has discretion to provide or deny a parent access to the minor’s health information.”

G. Variations Among State Laws

While HIPAA regulates protected health information for all covered entities in the United States, the HIPAA Privacy Rule specifically defers to the states in child welfare matters. The child welfare system differs substantially between states and, at times, between counties within a given state with regard to medical information sharing in the child welfare context. Missouri, for example, provides caseworkers with great authority to obtain medical records. In fact, Missouri requires caseworkers to obtain initial medical information and to provide that information to the child’s foster care provider within seventy-two hours of the child entering foster care. Additionally,

139 See 45 C.F.R. § 164.502(g)(2). The Code of Federal Regulation provides:

If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

Id.


Regardless, however, of whether the parent is otherwise the personal representative of a minor child, the Privacy Rule defers to State or other applicable laws that expressly address the ability of the parent to obtain health information about the minor child. In doing so, the Privacy Rule permits a covered entity to disclose to a parent, or provide the parent with access to, a minor child’s protected health information when and to the extent it is permitted or required by State or other laws (including relevant case law). Likewise, the Privacy Rule prohibits a covered entity from disclosing a minor child’s information to a parent when and to the extent it is prohibited under State or other laws (including relevant case law).

Id.

141 Id.

142 See supra notes 116, 132, 139, and accompanying text.

143 See MISSOURI DEPT OF SOCIAL SERVS., CHILD WELFARE MANUAL § 4, ch. 24.2 (Sept. 3,
Missouri requires the caseworker to establish and maintain a separate medical record for each child and each record is required to include all existing medical records on the child. Some states, like California, have taken proactive steps in researching, discussing, and identifying ways to create an integrated system of medical information sharing that comports with federal and state laws and regulations. The Administrative Office of the Courts, Center for Families, Children, and the Courts of California released a brief summarizing the issues faced by child welfare agencies, juvenile courts, and health care providers with regard to sharing health care information in the foster care setting. The brief concluded that “[r]emoving unnecessary barriers to sharing health information for the coordination of health care services for children in foster care is a priority. . . .” The purpose of the brief was “[t]o provide an overview of laws to

2013). The manual provides:

> [t]he Children's Service Worker will ensure initial medical information is obtained from the parent/physician and given to the resource provider within 72 hours, if possible, but no later than 30 days following placement. The Foster Parents' Bill of Rights . . . entitles foster parents to full disclosure of all medical, psychological, and psychiatric conditions of the child.

Id.

assist in the discussion of how best to remove unnecessary barriers to information sharing.”

Other states have laws requiring parental consent for disclosure of certain PHI, or the state laws provide disclosure guidance in limited circumstances. Along with variances across state disclosure laws, the state’s child welfare procedures and policies for transmitting information across different county agencies can be slow and inefficient, proving to be a barrier to ensuring quality health care to foster children.

In addition to the diverse patchwork of state laws and regulations, HIPAA further complicates the issue of timely disclosure with some of HIPAA’s exceptions. Under HIPAA, where a minor can consent to his or her own medical care, the minor’s personal representative does not control the PHI related to the medical care. Some

---

148 Id.
149 See, e.g., 55 PA. CODE § 5100.33(a) (LexisNexis 2015) (requiring parental consent to release PHI associated with mental health care).
150 See ROSADO ET AL., supra note 12, at 35. In Pennsylvania, for example, there are many cases where “[t]he confidentiality laws and regulations do not specifically address disclosure to [the child welfare] actors . . .” Id.
151 See, e.g., INST. FOR RES. ON WOMEN AND FAM., supra note 145, at 2. For example, California has a county-based health system, with varying policies among counties. Id. Some counties require that foster children be enrolled into managed care plans, while in other counties enrollment is voluntary. Id. The managed care is organized to support children who stay in one place and see one provider, but children in foster care are highly mobile. Id. In addition, the managed care plan is not accepted by many medical providers because of red tape. Id. As a further problem, foster care providers typically are not trained on how to access complex county-based health systems. Id. Thus, along with lack of adequate medical records, the fragmented health delivery system exacerbates the problem of foster children not receiving adequate health care. INST. FOR RES. ON WOMEN AND FAM., supra note 145 at 2.
152 45 C.F.R. §§ 164.502(g)(3)(i)(A)-(C); David M. Vukadinovich, Minors’ Rights to Consent To Treatment: Navigating the Complexity of State Laws, 37 J. HEALTH L. 667 (2004). Providers must pay close attention to patient consent and confidentiality laws when treating a minor because minors act as individuals on their behalf under the HIPAA exceptions. Id. For example, when a parent, guardian or person acting in loco parentis brings his or her child for treatment of an infectious disease, HIPAA bars the healthcare provider from disclosing the minor’s protected health information to the person if an enumerated exception is triggered. Id. at 668-69.
153 45 C.F.R. § 164.502g(3)(i) (delineating circumstances where unemancipated minors can act on their own behalf with respect to PHI). Applicable laws may authorize a parent, guardian or other person “to act on behalf of an individual who is an unemancipated minor in making decisions related to health care . . .” Id. Only the consent of the minor acting on his or her own behalf must consent and the minor must not request that the parent, guardian or other person be treated as the personal representative; “[a] parent, guardian, or other person acting in loco parentis assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.” Id.
states allow minors, who have reached a certain age, to consent to mental health treatment, substance abuse treatment, and reproductive health treatment. While these minor consent laws likely encourage adolescents to seek treatment by promising privacy to the adolescents, the details of these medical interactions are crucial to providing adequate care and funding for the children in the foster care system, and may otherwise not be sufficiently documented.

III. Solutions

Several possible solutions exist that could improve, or at the very least, reform how PHI is distributed within the foster care system. Three possible sources of solutions can be found in federal administrative action, changes to state law, and judicial orders.

A. Federal Administrative Action

Where the HIPAA Privacy Rule presents any barrier to access of a foster child’s medical information, several administrative tools could diminish the federal privacy barrier. First, HHS could amend the Privacy Rule provisions that address unemancipated minor children. HHS has a helpful precedence, the Uninterrupted Scholars Act. The Uninterrupted Scholar Act is a federal law, not a regulation, providing an exception to the general consent rule. The Uninterrupted Scholar Act

154 CAL. HEALTH & SAFETY CODE § 124260(b) (2011). In California, minors over the age of twelve can consent to outpatient mental health treatment if the mental healthcare provider finds that the minor is mature enough to participate in the treatment. Id. See, e.g., N.Y. MENTAL HYG. LAW § 33.16(c)(2) (2004). In New York, a minor over the age of twelve can object to disclosure of his or her mental health record in response to a request from a qualified person. Id. See, e.g., CONN. GEN. STAT. § 17a-688(d) (2012). In Connecticut, minors can give legal consent to receive treatment for alcohol or drug dependence, and the fact that they sought or received treatment may not be disclosed to their parents or legal guardian without the minor’s consent. Id. See, e.g., FLA. STAT. § 743.065 (2014). In Florida, a pregnant minor can consent to medical and surgical care related to her pregnancy. Id.

155 See supra notes 125-126 and accompanying text (discussing privacy rule provisions for unemancipated minor children).

156 Uninterrupted Scholars Act (USA), Pub. L. No. 112-278, 126 Stat. 2480 (2013) (amending FERPA to add that information about child’s education can be released to agency caseworker). Uninterrupted Scholars Act (USA) was signed into law by President Barack Obama on Jan. 14, 2013, and amends Section 444 of the General Education Provisions Act which is commonly known as FERPA. Id.

exception permits educational institutions to disclose a child’s educational records, without parental consent, to an agency caseworker or to a representative of a local child welfare agency. The Act permits individuals or entities that are legally responsible for the child and “engaged in addressing the student’s education needs” to receive the child’s educational records. The Act’s exception defers to states’ laws and regulations to some extent. For instance, the exception allows states to determine which actors in the child welfare system can access the child’s educational records. Additionally, the Act defers to other state laws regarding confidentiality of educational records.

conditions prior consent is required for disclosure of educational records).

20 U.S.C. § 1232g(b)(1)(L) (2012) provides the following:

(1) No funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of education records (or personally identifiable information contained therein other than directory information. . . ) of students without the written consent of their parents to any individual, agency, or organization, other than to the following—

(L) An agency caseworker or other representative of a State or local child welfare agency, or tribal organization . . . who has the right to access a student’s case plan, as defined and determined by the State or tribal organization, when such agency or organization is legally responsible, in accordance with State or tribal law, for the care and protection of the student, provided that the education records, or the personally identifiable information contained in such records, of the student will not be disclosed by such agency or organization, except to an individual or entity engaged in addressing the student’s education needs and authorized by such agency or organization to receive such disclosure and such disclosure is consistent with the State or tribal laws applicable to protecting the confidentiality of a student’s education records.

Nothing in subparagraph (E) of this paragraph shall prevent a State from further limiting the number or type of State or local officials who will continue to have access thereunder.

Id.

Id.

20 U.S.C. § 1232g(b)(1)(L) (2012) (explaining that State has power to determine what actors have right to access educational records). “[A]s defined and determined by the State.” Id.

20 U.S.C. § 1232g(b)(1)(L) (2012) (deferring to state law for guidance on confidentiality of educational records). Reference is “in accordance with State or tribal law.” Id.
The HIPAA Privacy Rule could, like the FERPA amendment, better define which state actors may access a child’s medical records and which agencies or institutions may receive these records over the course of the child’s journey in the foster care system. The provisions in FERPA serve as a model template in this instance. As discussed above, FERPA permits caseworkers or other representatives of the state to access a child’s educational record in order to address the child’s educational needs. Similarly, the Privacy Rule could give deference to the state while promoting the sharing of medical information to those who are legally responsible for caring for a child’s medical needs. Like FERPA, the Privacy Rule could allow states to keep their own laws and regulations that address medical information sharing (where the state has elected to do so) and permit states to define which actors in the child welfare system may access the child’s medical information.

Second, HHS could waive its enforcement of the Privacy Rule’s regulations where the regulations affect a child in the midst of dependency proceedings in a jurisdiction that has failed to implement laws providing for medical information sharing within the foster care context. Recent precedence indicates that administrative agencies have the ability to waive enforcement: amid public and political pressure after a slew of insurance policy cancellations under the Affordable Care Act, the Obama administration “announced a transition period allowing for the renewal of cancelled plans and policies between January 1 and October 1, 2014.” Since some health insurance insurers refused to renew cancelled policies, HHS provided an exemption to individuals who no longer had insurance coverage. Citing the ACA’s hardship exemption, HHS allowed those individuals to purchase catastrophic coverage, a type of coverage that is typically limited to individuals under thirty years of age. In a similar fashion, HHS could refuse

162 See supra note 158 (providing individuals with access to records).
165 See Options Available for Consumers with Cancelled Policies, supra note 161 (outlining aspects of
to enforce the Privacy Rule where HIPAA covered entities disclosed PHI to CPS agencies for a period of time. However, these solutions—amending the Privacy Rule and issuing exemptions—only ease the federal medical privacy burden. The state medical privacy laws could present barriers to medical information sharing.

B. Changes to State Laws

As mentioned, state laws vary widely. Missouri, for example, permits the CPS agency access to the child’s medical records. Pennsylvania, on the other hand, has a patchwork system of laws guiding actors in the foster care context. States themselves could create a comprehensive set of laws on medical information sharing. This solution is flexible, as it would allow the state to narrowly tailor their laws based on the state’s population. First, the HIPAA Privacy Rule defers to state law, allowing states substantial flexibility in drafting laws and regulations. Second, states are likely in the best position to tailor laws related to medical information sharing to the needs of their population and to their unique system of child welfare. At the very least, state laws should specify the persons and entities within the CPS system that can access and disclose a child’s confidential information.

C. Judicial Orders

A judicial order can be an effective tool to overcome restrictive federal and state laws. Some states grant courts the power to compel parties outside of the child welfare system to comply with requests for information. The court order may occur at any

hardship exemption process); Guidance on Hardship Exemptions for Persons Meeting Certain, supra note 164 (discussing hardship exemption).

166 See supra notes 52, 70, 76 (describing variations among states’ provision of access to medical records).

167 MO. REV. STAT § 210.150 (LexisNexis 2015) (outlining persons who may have access to child abuse and neglect investigation records); MO. REV. STAT § 211.319 (LexisNexis 2015) (describing persons who may have access to various child confidential files in a court proceeding); supra notes 142-143 and accompanying text (discussing Missouri laws regarding access to child medical records).

168 See supra notes 148-149 and accompanying text (discussing stricter confidentiality of child medical records in various states such as Pennsylvania).

169 See supra note 133 (detailing federal deference to state law).


171 See, e.g., FLA. STAT. ANN. § 39.301(12) (LexisNexis 2015) (permitting CPS to seek court order
time during the dependency proceeding, making this a flexible but narrow tool as it would apply only to the child or circumstances under review. Where the court orders access to a child’s medical records at the beginning of the case, CPS will have a better understanding of the child’s medical status and how best to meet the child’s medical needs. The problem with relying only on judicial orders is that state law may complicate the sharing of information even where the court grants CPS access to the child’s medical records. For instance, the state’s laws may be actively restrictive as to who may obtain a child’s medical records or silent on which entities may have access to this valuable information.

IV. Conclusion

The child welfare system is a complex network of various interested parties. Some of these interested parties include the child, the parent, the judge, CPS, the child’s GAL and the foster care providers. Each of the parties must make important decisions. It is essential that these parties base their decisions on adequate information. Decisions pertaining to one of the most important facets of a child’s care—meeting the child’s unique health care needs—are often made without the necessary information. State and federal laws create barriers to accessing a child’s medical record. There are several possible solutions to overcome barriers to obtaining confidential medical records. Among the solutions considered, state law reformation seems to be the most elegant solution to this conundrum. States are in the best position to create information sharing networks based on their unique child welfare systems, populations, and access to resources.