

THEIMANN

ADVISORY

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November 2016

FAQ on Services to Minors of Divorced Parents

Introduction

Theimann Advisories are periodic commentaries on the ethical, legal, and clinical implications of complex service dilemmas. They are issued with the support of the Smith P. Theimann, Jr. Distinguished Professorship in Ethics and Professional Practice and are distributed to alumni, students, and field instructors affiliated with the UNC Chapel Hill School of Social Work, as well as to the broader community of service providers.

Advisories use laws, ethics, and professional standards to craft recommendations in response to specific practice questions. They are intended to provide general guidelines for practice, but are not a substitute for legal advice or professional consultation and supervision on specific case matters. This *Advisory* utilizes North Carolina statutes in examining the issues presented. As such, some advice may not translate to other jurisdictions. Changes in laws, regulations and practice guidelines that occur after the advisory is issued may also affect the relevance of the recommendations.

This *Advisory* addresses the challenges presented in providing mental health or counseling services to minor clients whose parents are divorced or separated. It is intended to apply to the array of helping professionals, including social workers, counselors, and psychologists in a variety of child and adolescent service settings. Any meaningful distinctions among settings or types of professionals will be noted in the *Advisory*.

Understanding Custody

All states have statutes addressing custody of minor children. Few, however, define the terms used in discussing this issue. North Carolina is no different in this regard. The common understanding of “custody of a minor” refers to all the obligations and rights associated with the care, protection and control over the minor child.

The law uses the term “legal custody” to refer to the rights and obligations associated with making significant decisions affecting the child’s life. These typically relate to health, schooling, religious instruction and other issues with long-term implications for the child. If one parent has the right to make all major decisions for the child that parent is commonly understood to have sole legal custody. If both parents share the right to make major decisions, or if certain decisions are

divided between them, then it is assumed both parents have joint legal custody. The parent(s) with legal custody has the right to make these decisions even if financial support comes from somewhere else (Lee's North Carolina Family Law, §13.2b).

“Physical custody” refers to the obligations and rights of the person with whom the child resides. The parent with physical custody has the right to supervise the child, however decision making is limited to matters associated with the child's routine needs. Decisions such as where the child will attend school or what significant medical treatment the child might undergo typically have long-term consequences and therefore may only be made by the parent with legal custody. If the minor child resides with only one parent for significant periods of time then that parent is referred to as having primary physical custody or sole physical custody (Lee's North Carolina Family Law, §13.2c).

The standard used by the courts for determining custody of the minor child during divorce and separation proceedings is “the best interest of the child” (Lee's North Carolina Family Law, §50-13.2). “In North Carolina and in every state, a court may modify its order on the custody of a minor upon a change of circumstances affecting the welfare of the child” (Lee's North Carolina Family Law, §13.98a pg. 13-177). Parents are able to modify a court order regarding custody. To do so, courts require that there has been a substantial change of circumstances that affects the minor child and that modification is in the best interest of the child (Lee's North Carolina Family Law, §13.99). Thus, parents cannot seek modifications for trivial matters, but might do so if, for example, one parent was required to pay for medical expenses but then lost his/her job, or if the custodial parent became ill and was unable to fulfill that role as expected.

Since statutory law in North Carolina is silent on terms related to custody, this often contributes to problems when courts, lawyers, and custody orders fail to explain the agreements made between the parents. It is good practice that rights and responsibilities of each parent are clearly delineated in custody orders and that terms, such as joint custody, are fully explained. In fashioning a custody order, the court may also include a mechanism for resolving disagreements between parents with joint legal custody. In some jurisdictions, an “allocated parenting” agreement may be drafted to specify the rights and responsibilities between two competent but conflict-prone parents. These documents specify responsibility for significant events (visitation for holidays, payment of medical or dental expenses) as well as benign, but common, areas of dispute (payment for school clothes, field trips, summer camp, sports teams). Such “parallel parenting” arrangements anticipate disputes and attempt to address them proactively, removing children, therapists, health care providers, and others from conflicts between former spouses.

Frequently Asked Questions

1. If a parent brings a minor in for counseling, must the clinician/agency inquire about the presence of another parent and that person's consent for treatment? Does this change if payment/insurance is in the name of another adult?

Under North Carolina Law (N.C. Gen. Stat. §32A-30) the consent of one custodial parent would suffice, however practice advice suggests that the consent of both parents should be sought at the outset of (or before) treatment. Even though a non-custodial parent's consent is legally immaterial (DeKraai & Sales, 1991; Lawrence & Kurpius, 2000), it may still be ethically and clinically advisable to seek that person's assent (agreement) to treatment (Koocher, 2007). Seeking consent of both parents serves a number of functions. It preemptively identifies disagreements between the parents about the nature of the child's difficulties and need for treatment. This information may prove relevant for case assessment and treatment planning. The transparency in involving both parents fulfills the ethical principles of veracity and fidelity (truthfulness and trustworthiness) and reduces the likelihood that the child or therapist will be triangulated between the parents.

Contacts with estranged or angry ex-spouses may be uncomfortable for all involved (and may be resisted by the parent presenting for service). Yet as Koocher suggests, “A parent who truly seeks to serve only the best interests of the child will not object to allowing contact with the other parent or to providing necessary documentation” to facilitate contact (2007, p. 12). Alternatively, the clinician may recommend that the presenting, custodial parent converse with the other parent about the decision to seek treatment in lieu of the clinician pursuing contact and securing permission.

Neither scenario is easy: work with minors of divorced or separated parents clearly lies as much in the field of family therapy as it does in specialty of child and adolescent treatment. Obtaining the consent of both parents involves navigating emotionally-charged and history-laden territory. Clinical resources can provide guidance about the dynamic issues following marital dissolution and reintegration and the steps for helping parents come to terms with these challenges for the benefit of their children (Blow & Daniel, 2002; Visher & Visher, 1989).

Should the clinician decide to render treatment based solely upon one custodial parent's permission, he or she should discuss the possible repercussions of this stance with the parent (and the minor client, if age-appropriate). For example, if the parent with shared custody finds out about the treatment and objects to it, what steps must be taken? What will the agency disclose if the other parent seeks information about the care of the child, after discovering treatment absent his or her consent? These scenarios are addressed below, but their likelihood of occurring can be diminished if mutual consent is sought up front.

In any of these cases, the clinician should be certain to document the conversation and resulting decisions in the client's case record. Sound ethical decision making would also suggest that the worker discuss it with a supervisor, consultant, or knowledgeable colleague and document those findings as well (Strom-Gottfried, 2007)

A parent's obligation to pay a dependent's medical expenses is established as part of the divorce proceedings and is typically recorded in an order or agreement. The responsibility for payment is separate from custody and the capacity to give consent. Under an agreement of support, the custodial parent's authorization for service is valid by law. N.C. Gen. Stat. §50-13.11 outlines the procedures for the provision of health care and health insurance to minors. Either the court will assign the responsibility to one of the parents, or the parents enter into an agreement for medical support. According to sub-chapter (d), "When a court order or agreement for health insurance is in effect, the signature of either party shall be valid authorization to the insurer to process an insurance claim on behalf of a minor child." (see N.C. Gen. Stat. §50-13.11)

Although a non-custodial parent's consent for service is irrelevant, even if he or she is required to pay for the service, the clinician should still determine that person's role at the outset of treatment. As suggested above, informing this individual of the services and soliciting this person's assent for the treatment seems both ethically fair and clinically sound.

2. *What obligation does the agency have to secure documentation that verifies custody status? How frequently should the agency request documentation? What type of documentation is sufficient?*

Prudent practice suggests that the agency seek a copy of all materials related to the child's legal status. In cases of divorce, this would include obtaining a copy of the divorce decree (Carmichael, 2006) or "order of custody" and including it in the patient's record. Because circumstances can change (remarriage, job loss, relocation, etc) and parents can seek to alter an order, agencies should have a recommended schedule by which copies of orders are routinely sought (every six months, for example). In addition, if the clinician is aware of changes in family circumstances, he or she should seek copies of new orders outside that schedule as warranted.

3. *How is informed consent executed with the other parent?*

Ideally, the clinician would meet with the parents in person, individually or jointly to discuss the purpose, risks and costs of services, and available alternatives. The clinician should also describe the parents' rights to withhold or withdraw consent and any consequences of doing so (for example, implications for the child's condition, reports back to referring agencies, etc.). This information should be rendered in clear and understandable language, and reiterated as necessary throughout the treatment process. In addition to securing verbal consent, a formal, standardized informed consent document should be signed by both parents (Carmichael, 2006; DeKraai & Sales, 1991; Lawrence & Kurpius, 2000).

Typical informed consent conversations include discussions about the limits of confidentiality (suspected abuse, danger to self or other) and the clinician's policies on sharing content from counseling sessions with the client's parents. In cases involving divorced or estranged parents informed consent should also address the clinician's stance on sharing information with the other custodial parent. The obligation to share information with another custodial parent is addressed elsewhere in this *Advisory*.

In regard to non-custodial parents, the clinician's obligations are less clear. Some jurisdictions or divorce decrees might specify that parent's right to information. In other instances, the parent's access would be determined by the provider's preferences and the facts of the case. As such, the therapist may be willing to offer the non-custodial parent full, limited, or no access to case information. The important point is that the parameters should be made clear to all parties as part of the informed consent process and their agreement to that plan secured.

Because of distance and other factors, face-to-face meetings are sometimes impractical or impossible to arrange. The alternatives in this case include one-on-one phone conversations, a conference call with both parties, or letters to the parents. Verbal interactions clearly offer the opportunity for greater depth of explanation, and opportunities for questions and answers and for testing understanding of information shared. These correspondences can reference a written consent form which should be signed and returned to the agency.

4. *What difference does it make if the parents have joint custody or one has sole custody?*

If one parent has sole legal custody, then consent of that parent alone is sufficient for treatment. It is not necessary to seek consent from the other parent as that parent does not have legal decision making ability, however as discussed above, it may be clinically appropriate to seek the consent of both. If the parents have joint legal custody, then either parent may consent, but again, involving both adult figures may have therapeutic benefits and avoid disruptions later in the process.

5. *What are the clinician's responsibilities in situations where both parents have legal custody but one parent consents to treatment and one refuses (for example, on the basis of cost or disputations about the need for or value of counseling)?*

If the clinician agrees that treatment is unnecessary he or she can refuse to treat, explain and document the rationale, and suggest mechanisms by which the parents can more effectively resolve their differences about the care of their children. In the more common scenario, the clinician concurs with the need for treatment and thus is faced with a potential conflict of interest, in which advocating for treatment (ostensibly with him/her) is in his or her self interest and also allies the clinician with one parent and against another, when the cooperation of both is usually needed for the benefit of the child.

One way out of this entanglement is for the helping professional to address the parents' dispute as a singular goal for work. Should the parties be able come to an agreement to proceed with therapy for the child, that service would be provided by another professional or agency. Assisting an estranged couple to effectively communicate and create processes for addressing their children's needs is a worthwhile clinical objective in its own right, not simply an instrumental step to facilitate service to the child (Blow & Daniel, 2002; Visher & Visher, 1989).

Should the parents' impasse prove to be intractable, three further options exist. One would be for the parents to litigate the dispute so that a court stipulates parental rights as part of revised orders governing their custody arrangements and responsibilities. The disadvantages of this step are the cost, time involved and the perpetuation (and perhaps entrenchment) of existing conflict. In some cases, a court may intervene to force treatment against a custodial parent's wishes (Feigenbaum, 1991-1992). Courts may intervene over the objections of parents when the consequences of failing to provide treatment are severe and the treatment sought involves little risk to the child. (Lee's North Carolina Family Law, §50-15.29 f). Numerous court cases have upheld the court's authority to order medical treatment when a parent unreasonably withholds consent though these cases typically concern invasive medical procedures that substantially affect the child's health or safety, rather than less urgent matters of mental health or other forms of counseling. In processes such as this, a petition is filed for a judicial finding that the child is neglected or dependant and a guardian ad litem is appointed to represent the minor's interests "in any proceeding, formal or informal" (Feigenbaum, 1991-1992, p. 843). This helps assure that the child's needs are not subordinated to the parent's enmity for each other or their individual interests.

Options to adjudication include alternative dispute resolution (ADR) processes such as arbitration or mediation in which the parents would work with an individual trained to help the parties air their differences, hear the others' perspective, and reach a mutually agreeable conclusion. In some instances, arbitration is binding, and in those, the decision of the arbitrator, not the individuals, would take precedence. While ADR is less adversarial than adjudication of grievances, it can be time consuming, and must be carefully constructed so that the less powerful or vocal party is not disadvantaged in negotiations or compromise. In some high-conflict divorces, the involvement of a guardian ad litem (GAL) may be mandated

by the court. In this event, the GAL would be an appropriate resource for arbitration or mediation of this and other areas of disagreement.

As a final option to parental disputes about minor's care, the case could be referred to child welfare authorities for determination of medical neglect. Chapter 7B of the NC General Statutes outlines the policies and procedures for adjudication of cases of juvenile abuse, neglect, and dependency. The code includes in the definition of a neglected juvenile any minor "who is not provided necessary medical care; or who is not provided necessary remedial care" (N.C. Gen. Stat. § 7B-101. Definitions). Cases of neglect may also connote abuse if the responsible adult "creates or allows to be created serious emotional damage to the juvenile;" which is "evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others" (NC GS § 7B-101. Definitions). Cases of abuse may be pursued by law enforcement, and entail criminal proceedings.

It is wise to seek consultation from experts in child welfare and/or child protective service personnel prior to making a referral on the basis on medical neglect. While such referral may in some instances be clearly necessary for the worker to fulfill his or her role as a mandated reporter, ambiguous or punitive referrals by professionals (or a disaffected parent) will likely escalate conflict and alienation rather than a resolution that is ultimately helpful to the child.

6. *What if the parent presenting for service explicitly requests that the other parent not be contacted because of some compelling reason (a history of explosive anger, abuse, instability, or paranoia)?*

There may indeed be situations in which it is impractical, unsafe, or unsound to involve a noncustodial parent in assenting to the child's treatment. If the reasons for excluding the other parent are formally documented (for example, incarceration or termination of parental rights) "the word of one parent should require corroboration (e.g. a confirmatory letter from a member of the bar or a copy of a court order)" (Koocher, 2007, p.12). If the concerns have not been formally established, the clinician should explore the basis for the presenting parent's apprehensions, any substantiation for the parent's claims, the nature and scope of the anticipated services, and the implications of serving the child without informing the other parent. The clinician should seek consultation about the implications of proceeding with treatment and review those with the presenting parent. For example, what are the likely repercussions (for the child client and others) if the noncustodial parent learns of the treatment and demands access to records or other information about the care provided? If the clinician ultimately determines that consulting with both parents is contraindicated (or that one parent should be denied access to records) the clinician should document the steps taken to reach this decision and the information supporting it.

7. *What responsibility does the agency have to share information with the other parent if he/she seeks information about the status of that child's care? Does this obligation differ if the parent requesting information is non-custodial?*

According to Corbet (2006) divorced parents have equal access to their child's record unless a court order specifies differently. N.C. Gen. Stat. §50-13.2 reads, "Absent an order of the court to the contrary, each parent shall have equal access to the records of the minor child involving the health, education, and welfare of the child." Therefore, both parents have equal rights to the medical records upon request, barring any other scenarios that would preclude disclosure (i.e., when the disclosure serves the parent's interest and is not in the best interest of the child). It is important though, to differentiate the right of access from the right to give consent. While access to records may be available upon request, a parent without legal custody may not consent to significant medical/psychiatric treatment.

The NASW Code of Ethics (2008) stipulates that "social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files" (1.08). While the Code does not differentiate minor's records from those of adult clients, the guidance provided about access, limits, and documentation of related decisions is germane to minors' records and parental access.

8. If a grandparent (or other non-parent relative) brings a minor in for counseling, must the clinician/agency inquire about the parent? What if the parent is incarcerated, resides in another state, is hospitalized or otherwise unavailable?

N.C. Gen. Stat. §32A Article 4 (see Appendix below) outlines procedures for “delegating the decisions to health care for the parent’s minor child when the parent is unavailable for a period of time by reason of travel or otherwise.” In the following section we discuss the conditions under which services should be rendered without a parent’s consent. In instances other than those described below, it seems unwise to serve a minor on an extended basis without parental permission, even though the minor may be presented for service by a relative or other responsible adult.

This is clearly an ethical dilemma, in that the duty to serve, especially in a compelling case of a distraught or needy minor, is in conflict with a parent’s right to approve or disapprove of non-emergency services for his or her child. A clinician or agency may bridge this divide by providing circumscribed and time-limited assistance in the case, for example, meeting with the minor and presenting adult in order to assess the situation, rule out emergent circumstances, and advise the adult on steps to secure custody. Assisting the adult may include providing a list of attorneys who could help with custody proceedings, consulting with child welfare authorities about their jurisdiction or assistance in the case, and exploring with the adult the assistance and documentation needed to carry out other responsibilities for the minor. If the provider believes that more extensive involvement is warranted without parental permission, he or she should seek legal, ethical and clinical consultation about the impetus for this decision and other available options. Possible consequences for agencies or individuals who provide non urgent services without parental consent include complaints to licensure or regulatory authorities and civil actions.

9. In what situations can treatment be given to minors without parental consent?

Jill Moore (2005) notes five situations mentioned in the General Statutes which constitute exceptions to the parental consent mandate. 1) Parent authorizes another adult to give consent [GS 32A-Article 4]; 2) Emergencies and other circumstances [GS 90-21.1]; 3) Immunizations: A physician or local health department may immunize a minor who is presented for immunization by an adult who signs a statement that he or she has been authorized by the parent, guardian, or parent *in loco parentis*, to obtain the immunization for the minor [GS 130A-153(d)]; 4) Emancipated minors [GS 90-21.5]; 5) Minor’s consent law [GS 90-21.5] allows physicians to accept unemancipated minors’ consent for treatment for the prevention, diagnosis, or treatment of venereal and other reportable communicable diseases, pregnancy, abuse of controlled substances or alcohol, or emotional disturbance. Exceptions to the rule include: sterilization, abortion, or admission to a 24-hour mental health or substance abuse facility (except in an emergency). Note: a health care provider must not accept a person’s consent to treatment without evidence of *decisional capacity* to do so. Thus the consent must be voluntary, knowing and competent (Sales, DeKraai, Hall, & Duval, 2008).

Acknowledgements

The authors wish to thank Dr. Shelley Cohen-Konrad of the University of New England school of Social Work for sharing her expertise in reviewing earlier versions of this *Advisory*.

References and Resources

- Blow, K., & Daniel, G. (2002). Frozen narratives? Post-divorce processes and contact disputes. *Journal of Family Therapy*, 24, 85-103.
- Carmichael, K. D. (2006). Legal and ethical issues in play therapy. *International Journal of Play Therapy*, 15, 83-99.
- Corbett, L. G. (2006). Balancing the rights of minors and parents. In *Legal Issues in Behavioral Health*. Medical Educational Services, Inc. Professional Development Network.
- DeKraai, M. B., & Sales, B. D. (1991). Liability in child therapy and research. *Journal of Consulting and Clinical Psychology*, 59, 853-860.
- Ehrenreich, N. S., & Melton, G. B. (1983). Ethical and legal issues in the treatment of children. In C. E. Walker & M. C. Roberts (Eds.), *Handbook of clinical child psychology* (pp1285-1305). New York: John Wiley & Sons.
- Feigenbaum, M. S. (1991-1992). Minors, medical treatment, and interspousal disagreement: Should Solomon split the child? *DePaul Law Review*, 41, 841-884.
- Koocher, G. P. (2007). All in the family. *Professional Psychology: Research and Practice*, 38, 11-12.
- Moore, J. (2005). Who may consent to a minor's medical treatment? Overview of North Carolina law. UNC Institute of Government. Retrieved on February 10, 2009, from, <http://www.sog.unc.edu/programs/dss/2007WinterSpringConf/SS/PDF's/MooreMinorsTxFeb07.pdf>
- Reynolds, S. (2002). *Lee's North Carolina Family Law*. Fifth Edition. Vol. 3, LexisNexis/Matthew Bender & Company, Inc.
- Sales, B. D., DeKraai, M. B., Hall, S. R., & Duvall, J. C. (2008). Child therapy and the law. In, R. J. Morris, & T. R. Kratochwill (Eds.) *The practice of child therapy* (4th ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
- Strom-Gottfried, K.J. (2007) *Straight talk about professional ethics*. Chicago: Lyceum.
- Visher, E. B., & Visher, J. S. (1989). Parenting coalitions after remarriage: Dynamics and therapeutic guidelines. *Family Relations*, 38, 65-70.

Appendices

Emancipation in NC - (Corbet, 2006)

- Emancipation by petition (over age 16), or by marriage (as young as 14). Parental consent is required for 14-15 year-olds to marry.

North Carolina General Statutes

Chapter 90 (Medicine and Allied Occupations)

DeVito's note: There's language in this chapter that addresses some of the consent questions; however, the articles seem to be aimed (and limited?) to the practice of medicine. I'm not certain that either of these articles apply to counselors.

§ 90-21.1. When physician may treat minor without consent of parent, guardian or person in loco parentis.

It shall be lawful for any physician licensed to practice medicine in North Carolina to render treatment to any minor without first obtaining the consent and approval of either the father or mother of said child, or any person acting as guardian, or any person standing in loco parentis to said child where:

- (1) The parent or parents, the guardian, or a person standing in loco parentis to said child cannot be located or contacted with reasonable diligence during the time within which said minor needs to receive the treatment herein authorized, or
- (2) Where the identity of the child is unknown, or where the necessity for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the life of said minor, or
- (3) Where an effort to contact a parent, guardian, or person standing in loco parentis would result in a delay that would seriously worsen the physical condition of said minor, or
- (4) Where the parents refuse to consent to a procedure, and the necessity for immediate treatment is so apparent that the delay required to obtain a court order would endanger the life or seriously worsen the physical condition of the child. No treatment shall be administered to a child over the parent's objection as herein authorized unless the physician shall first obtain the opinion of another physician licensed to practice medicine in the State of North Carolina that such procedure is necessary to prevent immediate harm to the child.

Provided, however, that the refusal of a physician to use, perform or render treatment to a minor without the consent of the minor's parent, guardian, or person standing in the position of loco parentis, in accordance with this Article, shall not constitute grounds for a civil action or criminal proceedings against such physician. (1965, c. 810, s. 1; 1977, c. 625, s. 1.)

§ 90-21.5. Minor's consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child. (1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4.)

Chapter 32A – Powers of Attorney

§ 32A-28. Purpose.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of a parent to delegate decisions relating to health care for the parent's minor child where the parent is unavailable for a period of time by reason of travel or otherwise.

(b) The purpose of this Article is to establish a nonexclusive method for a parent to authorize in the parent's absence consent to health care for the parent's minor child. This Article is not intended to be in derogation of the common law or of Article 1A of Chapter 90 of the General Statutes. (1993, c. 150, s. 1.)

§ 32A-29. Definitions.

As used in this Article, unless the context clearly requires otherwise, the term:

- (1) "Agent" means the person authorized pursuant to this Article to consent to and authorize health care for a minor child.
- (2) "Authorization to consent to health care for minor" means a written instrument, signed by the custodial parent and acknowledged before a notary public, pursuant to which the custodial parent authorizes an agent to authorize and consent to health care for the minor child of the custodial parent, and which substantially meets the requirements of this Article.
- (3) "Custodial parent" means a parent having sole or joint legal custody of that parent's minor child.
- (4) **"Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or provide for a minor child's physical or mental or personal care and comfort, including life sustaining procedures and dental care.**
- (5) "Life sustaining procedures" are those forms of care or treatment which only serve to artificially prolong life and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of treatment which sustain, restore, or supplant vital bodily functions, but do not include care necessary to provide comfort or to alleviate pain.
- (6) "Minor or minor child" means an individual who has not attained the age of 18 years and who has not been emancipated. (1993, c. 150.)

§ 32A-30. Who may make an authorization to consent to health care for minor.

Any custodial parent having understanding and capacity to make and communicate health care decisions who is 18 years of age or older or who is emancipated may make an authorization to consent to health care for the parent's minor child. (1993, c. 150, s. 1.)

§ 32A-34. Statutory form authorization to consent to health care for minor.

The use of the following form in the creation of any authorization to consent to health care for minor is lawful and, when used, it shall meet the requirements and be construed in accordance with the provisions of this Article.

"Authorization to Consent
to Health Care for Minor."

I, _____, of _____ County, _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____, _____. I authorize _____, an adult in whose care the minor child has been entrusted, and who resides at _____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including _____, ____].

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

(SEAL)
Custodial Parent

Date

STATE OF NORTH CAROLINA

COUNTY OF

On this _____ day of _____, _____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires:

(OFFICIAL SEAL). (1993, c. 150, s. 1; 1999-456, s. 59.)

§ 50-13.11. Orders and agreements regarding medical support and health insurance coverage for minor children.

(a) The court may order a parent of a minor child or other responsible party to provide medical support for the child, or the parties may enter into a written agreement regarding medical support for the child. An order or agreement for medical support for the child may require one or both parties to pay the medical, hospital, dental, or other health care related expenses.

(a1) The court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance is available at a reasonable cost. If health insurance is not presently available at a reasonable cost, the court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance becomes available at a reasonable cost. As used in this subsection, health insurance is considered reasonable in cost if it is employment related or other group health insurance, regardless of service delivery mechanism. The court may require one or both parties to maintain dental insurance.

(b) The party ordered or under agreement to provide health insurance shall provide written notice of any change in the applicable insurance coverage to the other party.

(c) The employer or insurer of the party required to provide health, hospital, and dental insurance shall release to the other party, upon written request, any information on a minor child's insurance coverage that the employer or insurer may release to the party required to provide health, hospital, and dental insurance.

(d) When a court order or agreement for health insurance is in effect, the signature of either party shall be valid authorization to the insurer to process an insurance claim on behalf of a minor child.

(e) If the party who is required to provide health insurance fails to maintain the insurance coverage for the minor child, the party shall be liable for any health, hospital, or dental expenses incurred from the date of the court order or agreement that would have been covered by insurance if it had been in force.

(f) When a noncustodial parent ordered to provide health insurance changes employment and health insurance coverage is available through the new employer, the obligee shall notify the new employer of the noncustodial parent's obligation to provide health insurance for the child. Upon receipt of notice from the obligee, the new employer shall enroll the child in the employer's health insurance plan. (1989 (Reg. Sess., 1990), c. 1067, s. 1; 1991, c. 419, s. 2; c. 761, s. 42; 1997-433, s. 3.1; 1998-17, s. 1; 2003-288, s. 3.2.)