

# MaineHealth

Testimony of Dr. Daniel Nigrin  
Chief Information Officer, MaineHealth  
Before the Joint Standing Committee on the Judiciary  
In Opposition to LD 1510,  
“An Act Concerning Informed Consent of Minors’ Authority to Release Health Care  
Information”  
May 6, 2021

Senator Carney, Representative Harnett and Members of the Joint Standing Committee on the Judiciary, I am Dr. Daniel Nigrin, the Chief Information Officer at MaineHealth. I was previously the CIO at Boston Children’s Hospital, where I also practiced clinically as a pediatric endocrinologist for 25 years. Boston Children’s Hospital was one of the first in the country to provide children with electronic access to their medical records, so the topic of parental access is one that I have been involved with for many years.

Let me begin by saying that MaineHealth provides parents with access to their children’s medical information today, just as we did before we adopted our electronic patient portal – via paper records and in person or over the phone. This bill is not about access to legal medical information; it is about convenient access to minors’ medical information through recently adopted electronic portals. Yet the consequences of passing this bill could have significant clinical implications for minors with legally protected health care needs. Our concerns with the bill are:

1. Electronic health records do not currently have the ability to separate out all legally-protected confidential components of the visit, including family planning and behavioral health, from non-confidential ones.
2. The legislation states that **any** authorization of a minor to share medical records would result in release of the **entire** medical record electronically, including those provisions that are legally protected because they are sensitive in nature. A minor may perceive that they are giving their parent access to information related to their orthopedic injury, where in fact they are also inadvertently providing their parent with sensitive information such as they have started birth control, been tested for a sexually transmitted infection, or that they struggle with drinking or using illicit substances. Furthermore, the simple act of the teen **not** giving their consent, especially in the presence of a parent, could be harmful to that relationship as well, causing tension and distrust between them.

Confidentiality for an adolescent is a core part of a successful partnership between the provider and the adolescent. When a provider meets alone with an adolescent, they ask about dating, illicit substance use, and mental health. When confidentiality of these discussions is afforded to the patient, data shows that the teenager is more likely to share important health-related information or seeks answers to questions about their health. More importantly, some adolescents will *only* seek healthcare for such things as contraception or treatment of sexually transmitted infections if they are afforded such

confidentiality. If not, the adolescent's risk behaviors do not change, but their willingness to provide important information to their health care provider diminishes, and their provider's ability to assess and address those health issues in turn becomes far more limited.

Confidentiality is not always requested or needed by all patients. And providers currently have the ability to break confidentiality if a minor is making decisions that are truly harmful for them. Parents play a critical role as a partner in their child's health, and providers encourage their adolescent patients to include their parents in health decisions. However, our ability to screen and counsel for risk behaviors would be significantly hampered if we were not able to guarantee confidentiality for the patient. And those screens provide information that allows providers to identify – and treat – issues in their early stages, often preventing longer term illness.

The medical record reflects the patient-provider discussion as well as the tests and/or treatment provided during a patient's visit. As with the visit itself, the sensitive parts of the visit are intermixed into the rest of the documentation, and thus not easily removed from a record. When we provide paper records to parents, we are able to redact legally-protected information or remove it entirely before providing it to the parent. Today, current technology is not able to separate these sensitive parts out within the narrative notes in our electronic portals. This is a national problem that is recognized by EHR vendors. Once technology catches up with the law and sensitive information can be protected as appropriate, we will provide parents with electronic access to the non-confidential portions of the record.

Thank you for the opportunity to testify, and I would be happy to answer questions.