

IN THE
Supreme Court of the United States

INTERNATIONAL PARTNERS
FOR ETHICAL CARE, INC., *et al.*,
Petitioners,

v.

BOB FERGUSON,
GOVERNOR OF WASHINGTON, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

**BRIEF OF *AMICI CURIAE* YOUTH POWER
PROJECT, IDAHO ACADEMY OF FAMILY
PHYSICIANS, INDIANA ASSOCIATION OF
SCHOOL NURSES, INDIANA JUSTICE PROJECT
& COVERING KIDS & FAMILIES OF INDIANA
IN SUPPORT OF RESPONDENTS**

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INTEREST OF *AMICI CURIAE*¹

Amici are nonprofit organizations that provide or advocate for health care for youth. Amici submit this brief collectively to bring to the Court the perspectives of people who interact directly with the issue of minor consent, including youth, healthcare professionals, and organizations working to improve access to health care.²

Youth Power Project (“YPP”) is a youth-led initiative operating in nine states, including Texas, Tennessee, and Florida, and fiscally sponsored by Future Incubator, a nonprofit organization. YPP empowers and trains young people with adverse health experiences to shape public policy through advocacy and engagement with legislators. YPP’s interest in this case reflects its mission to ensure that laws governing youth health care meet the needs and experiences of young people. With their permission, YPP offers testimonials from its members and affiliates.

Idaho Academy of Family Physicians (“IAFP”) is a professional organization that represents Idaho family physicians and advocates for their patients and for policies that improve Idahoans’ health. IAFP’s interest in this case reflects its work to preserve physicians’ ability to provide appropriate care to minors consistent with professional standards and applicable laws.

1. Pursuant to Rule 37.6, amici state that no counsel for a party authored this brief in whole or in part, and no person or entity other than amici, their members, or their counsel made a monetary contribution intended to fund its preparation or submission.

2. Appendix 1 contains contact information for amici organizations.

Indiana Association of School Nurses (“IASN”), an affiliate of the National Association of School Nurses, is a professional organization that promotes children’s health and educational success by supporting school nursing. IASN’s interest in this case reflects its work to ensure that Indiana school nurses can appropriately respond to students’ medical needs within established legal frameworks.

Indiana Justice Project (“IJP”) is a nonpartisan, nonprofit legal advocacy organization promoting equal justice for Indiana residents. IJP helps low-income individuals obtain the health care they deserve. IJP’s interest in this case reflects its advocacy safeguarding legal protections for access to necessary health care, particularly for vulnerable youth.

Covering Kids & Families of Indiana (“CKF-IN”) is a nonprofit organization that engages in healthcare assistance, advocacy, and leads the Indiana School Health Network, working with families, schools, and healthcare professionals. CKF-IN’s interest in this case reflects its focus on ensuring access to necessary health care for young people and their families.

SUMMARY OF THE ARGUMENT

Every state has enacted laws allowing minors, in certain circumstances, to obtain some forms of health care without parental consent. Every day, children and youth across the country rely on these laws to access essential care, sometimes during urgent or life-endangering situations. These laws, known as minor consent laws, reflect legislatures’ careful judgments about when minors

can obtain care such as outpatient mental health treatment, emergency care, and treatment for sexually transmitted infections (“STIs”) in circumstances where requiring parental consent would harm youth’s health and safety.³ The minor consent law that Petitioners challenge—Wash. Rev. Code § 71.34.530 (“RCW § 71.34.530”), which allows youth to consent to outpatient mental health care—is not novel. Like its counterparts in many other States, RCW § 71.34.530 is vital to youth health and safety. The testimonials of youth and healthcare providers presented here show that these laws, common across the country, are necessary for youth well-being and, at times, lifesaving.⁴

Amici’s experience with these laws illustrates why Article III does not permit standing to Petitioners. Children and youth experience concrete harm when they cannot access health care without parental consent. Petitioners, by contrast, have suffered no legal harm from RCW § 71.34.530. A parent’s interest in a child’s upbringing, while very important, does not relieve Petitioners from showing a concrete, traceable injury

3. This Brief uses the term “minor consent laws” to refer both to laws that allow youth to consent to care, *see, e.g.*, RCW § 71.34.530, and to laws that allow minors to receive health care from permitted providers without parental consent. *See, e.g.*, Idaho Code Ann. § 32-1015.

4. This Court allows amicus briefs to present personal accounts, affidavits, and testimonials of relevant facts in aid of its decision-making. *See, e.g., Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) (taking into account some women’s personal accounts, presented through an amicus brief, about the regrets they had over their choice of abortion); *Moyle v. United States*, 603 U.S. 324, 342 n. _ (2024) (Barrett, J., concurring) (citing several amicus briefs for testimonials and affidavits).

caused by the operation of the particular statutes they challenge. Amici urge this Court to consider their experiences and insight, reject Petitioners' speculative allegations, and affirm.

ARGUMENT

I. Minor Consent Laws Have an Extensive History and Have Been Adopted by All States.

A. State Supreme Courts and Legislatures Have Long Recognized the Need for Minor Consent.

Minor consent is a well-established feature of the law, not a new development. Under the common law, U.S. courts have long allowed minors with sufficient maturity to give independent consent to medical treatment in some situations. *See, e.g., Cardwell v. Bechtol*, 724 S.W.2d 739, 744-45 (Tenn. 1987) (surveying case law since 1845 and concluding the “recognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century”); *Gulf & S.I.R. Co. v. Sullivan*, 119 So. 501, 502 (Miss. 1928) (permitting a seventeen-year-old of “sufficient intelligence to understand and appreciate the consequences of the vaccination” to consent to a measles vaccination); *Smith v. Seibly*, 431 P.2d 719 (Wash. 1967) (upholding consent to medical procedure by a minor who was then a married father).

Over decades, under what came to be known as the mature minor doctrine, many state supreme courts recognized the importance of minor consent in situations where the requirement of parental consent would delay or deny youth's access to timely medical care. *See, e.g.,*

Younts v. St. Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 332 (Kan. 1970) (allowing a seventeen-year-old to consent to treatment for a finger injury suffered while visiting her mother in the hospital after her mother’s “major surgery” that day); *Cardwell*, 724 S.W.2d at 748-49 (permitting a seventeen-year-old to independently consent to treatment for back pain).

Beginning in the 1950s, many states passed legislation adopting minor consent laws.⁵ These statutes allowed minors to consent to select types of health care essential to youth health and safety, such as emergency care, substance-use disorder treatment, prenatal care, and sexual assault examination; or authorized medical providers to offer such care to youth without parental consent. By 1972, forty-three states had passed laws allowing minors to access STI testing and treatment without parental consent, and twenty-five states had permitted qualifying minors to access pregnancy-related care and substance-use disorder treatment without parental consent.⁶

Contrary to Petitioners’ assertion,⁷ permitting minor consent in certain cases does not displace the general

5. Hannah L. Brown et al., *History of Minor Consent Laws for Mental Health Treatment in the US*, 7 JAMA Health F. e260927 (2026), <https://doi.org/10.1001/jamahealthforum.2026.0927>.

6. Jane E. Brody, *New Laws Help Minors to Receive Health Care Without Consent of Parents*, N.Y. Times (Mar. 5, 1972), <https://www.nytimes.com/1972/03/05/archives/new-laws-help-minors-to-receive-health-care-without-consent-of.html>.

7. See Pet’rs Br. at i (asserting that the minor consent laws under challenge “deliberately displace[] [parents’] decision making role”).

rule of parental consent. *See Cardwell*, 724 S.W.2d at 745 (“Adoption of the mature minor exception to the common law rule is by no means a general license to treat minors without parental consent . . .”). Rather, minor consent laws, including RCW § 71.34.530, supplement and complement the general requirement of parental consent by carving out exceptions where requiring parental consent would hinder, rather than facilitate, youth’s access to medical care. Empirical data confirms that despite the prevalence of minor consent laws, most minors still involve parents in their health care decisions.⁸ And even where youth access care through minor consent, many ultimately involve their parents and family in their health care, often with the encouragement and support of healthcare professionals. While minor consent opens the door to care, it does not close the door on parents.⁹ *See infra* Part II.B.

8. *See* Rachel K. Jones et al., *Adolescents’ Reports of Parental Knowledge of Adolescents’ Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 JAMA 340, 340 (2005) (surveying 1,526 minor girls seeking reproductive health services other than abortion, prenatal and postnatal care and finding that “sixty percent of minors reported that a parent or guardian knew they were accessing sexual health services at the clinic”).

9. Consent and confidentiality are distinct. Minor consent laws govern who may authorize care. Separate federal and state laws typically govern disclosure of information. Many permit or require disclosure to parents. *See* Abigail English & Rebecca Gudeman, Nat’l Ctr. for Youth L., *Minor Consent and Confidentiality: A Compendium of State and Federal Laws* (2026), https://static1.squarespace.com/static/66421681d90ded764d1347e8/t/6adbaeed253be37c68b8a360/1792782061982/NCYL_Compendium_2026_Full_FINAL.pdf.

B. Every State Has Adopted Some Form of Minor Consent Laws.

Today, all fifty states have passed some form of minor consent laws to ensure youth access to certain types of essential health care.¹⁰ As shown in the chart in Appendix 2, among all fifty states, forty-nine allow certain minors access to STI testing and treatment without parental consent; forty-eight to substance-use services; forty-five to emergency care; thirty-nine to prenatal care; thirty-five to outpatient mental health care; and twenty-four to sexual assault examination.

Although these laws differ by state,¹¹ they share one basic consensus—for youth health and safety, it is necessary in some situations to allow youth to access health care without parental consent. Indeed, even where state legislatures have recently passed laws limiting youth access to health care without parental consent, legislatures still acknowledge the need for some exceptions.

In 2022, Florida passed House Bill 817 to authorize emergency care for minors without parental consent. Act of Apr. 6, 2022, ch. 2022-53, 2022 Fla. Laws (codified at Fla. Stat. § 743.064(1)). The legislature’s bill analysis explicitly named Florida’s “obligation to ensure that children receive reasonable medical treatment that is

10. Supplementing minor consent laws, some states also passed statutes that allow a third party, such as the minor’s grandparents or siblings, to consent to minors’ medical treatment. *See, e.g.*, Tex. Fam. Code Ann. § 32.001(a)(1)–(3) (West 2025); Miss. Code Ann. § 41-41-3(1)(c)–(d) (2025).

11. *See* English & Gudeman, *supra* note 9.

necessary for the preservation of life.” Fla. H.R. Staff Analysis, H.B. 817, 2022 Leg., Reg. Sess., at 2 (Jan. 20, 2022). Republican State Senator Jennifer Bradley, sponsor of the companion Senate Bill 1114, explained that legislators “certainly do not want a physician to hold back from rendering lifesaving aid So this bill [allows] physicians to provide emergency medical treatment to minors anywhere such treatment is needed . . .”¹²

In 2023, the Texas Legislature passed Senate Bill 1401 to allow minor survivors of sexual assault to consent to forensic medical examination. Act of May 24, 2023, 88th Leg., R.S., ch. 206, 2023 Tex. Gen. Laws (codified at Tex. Code Crim. Proc. Ann. art. 56A). The bill’s sponsor stated that it would “ensure that victims receive appropriate medical care and evidence is properly collected for potential legal proceedings.” S. Comm. on Crim. Just., Bill Analysis, Tex. S.B. 1401, 88th Leg., R.S. (June 5, 2023). The bill’s committee report articulated a desire to “strengthen the rights of sexual assault survivors” to access forensic medical examinations. H. Comm. on Homeland Sec. & Pub. Safety, Bill Analysis, Tex. S.B. 1401, 88th Leg., R.S. (2023). Texas law likewise allows a minor to consent to counseling for “suicide prevention,” “chemical addiction or dependency,” and “sexual, physical, or emotional abuse.” Tex. Fam. Code Ann. § 32.004(a) (West 2025).

12. *Hearing on S.B. 1114 Before the S. Comm. on Judiciary*, 2022 Leg., Reg. Sess. (Fla. Jan. 18, 2022) (statement of Sen. Jennifer Bradley), <https://thefloridachannel.org/videos/1-18-22-senate-committee-on-judiciary/>.

In 2024, Idaho passed Senate Bill 1329 (“S.B. 1329”), which broadly requires parental consent for any health care service for minors. Act of Mar. 21, 2024, ch. 148, 2024 Idaho Sess. Laws 594 (codified at Idaho Code Ann. § 32-1015). The sweeping breadth of S.B. 1329 led Governor Brad Little to warn that it could create “unintended barriers for adolescent behavioral health care.”¹³ This concern was correct, and Idaho lawmakers came to realize a range of adverse impacts, including impeding access to hotline services¹⁴ and chilling the treatment of minors with STIs.¹⁵ To address some of these barriers, in 2026, Idaho lawmakers passed House Bill 860 (“H.B. 860”), which

13. Letter from Brad Little, Governor of Idaho, to Scott Bedke, President, Idaho State Senate (Mar. 21, 2024), https://gov.idaho.gov/wp-content/uploads/2024/03/transmittal_s-1329_2024.pdf.

14. Laura Guido, *Idaho’s Parental Consent Law Impedes 988 Suicide Crisis Hotline Access for Some Youth*, Idaho Cap. Sun (Aug. 29, 2025), <https://idahocapitalsun.com/2025/08/29/idahos-parental-consent-law-impedes-988-suicide-crisis-hotline-access-for-some-youth/>.

15. State Rep. Marco Erickson (R-Idaho Falls) called it a “terrible bill with terrible outcomes for the youth,” adding, “I tried to warn my fellow legislators . . . but I was one Republican voice among a group of people who do not understand how things work on the ground.” Karin Brulliard, *A Young Teen Gives Birth. Idaho’s Parental Consent Law Snags Her Care*, Wash. Post (Oct. 21, 2024), <http://www.washingtonpost.com/nation/2024/10/21/idaho-consent-law-teens-health-care/>. One Idaho lawmaker said, “[W]e were all in shock of what a mess [S.B. 1329] turned out to be.” Abby Wilt, *‘A Mess This Turned Out to Be’: Band-Aids Closer to Being Allowed in Idaho Schools Without Parental Consent*, KTVB (Mar. 11, 2026), <https://www.ktvb.com/article/news/local/208/band-aids-closer-being-allowed-idaho-schools-without-parental-consent/277-6414113f-aac3-4329-a825-25ebf3862680>.

allowed children to receive some medical care—including first aid, illness-identifying checks, access to crisis and suicide hotlines, and certain prenatal and perinatal care—without parental consent.¹⁶ Act of Mar. 31, 2026, ch. 245, 2026 Idaho Sess. Laws (codified as amended at Idaho Code Ann. §§ 16-2424, 32-1010, 32-1013, 32-1015, 66-318, 66-320).

In 2024, Tennessee passed a strict parental consent law, Senate Bill 2749, which was interpreted to require school staff to obtain parental consent for treating minor scrapes, cuts, and illnesses.¹⁷ Act of June 3, 2024, ch. 1061, 2024 Tenn. Pub. Acts (codified as amended at Tenn. Code Ann. § 63-1-176). Following criticism from the Tennessee Association of School Nurses Executive Board, Governor Bill Lee recognized that the General Assembly needed to consider an amendment, and the bill’s sponsor, Rep. Jeremy Faison (R-Cosby), explained that “[a]s the bill fleshed out, we did find some issues that we want to clarify.”¹⁸ The following year, Tennessee

16. Laura Guido, *Idaho Lawmaker Brings Draft Bill to Address Issues with 2024 Parental Consent Law*, Idaho Cap. Sun, (Mar. 10, 2026), <https://idahocapitalsun.com/2026/03/10/idaho-lawmaker-brings-draft-bill-to-address-issues-with-2024-parental-consent-law/>.

17. *TN Law Now Suggests that Parents Must Approve Band-Aids at School for Minor Scrapes, Scratches or Cuts*, WGNS (Aug. 13, 2024), <https://www.wgnsradio.com/article/88348/tn-law-now-suggests-that-parents-must-approve-band-aids-at-school-for-minor-scrapes-scratches-or-cuts>.

18. Marissa Sulek, *School Nurses and Counselors Feel Restricted After New Law Goes into Effect in Tennessee*, WSMV 4 (Aug. 12, 2024), <https://www.wsmv.com/2024/08/12/school-nurses-counselors-feel-restricted-after-new-law-goes-into-effect-tennessee/>; see also Vivian Jones, *Tennessee House Passes Bill*

law was amended to permit school employees to provide certain forms of non-emergency first aid to minors without parental consent, including ice packs, fluids, and dressing and topical agents for wounds. Tenn. Code Ann. § 36-8-103(d)(3) (2025).

Underlying this nationwide consensus for minor consent is the common understanding that the “need for parental consent can be a huge barrier to accessing health care, especially for minors who are homeless or . . . have run away,”¹⁹ as well as for minors whose parents are not in a position to give consent. *See Younts*, 469 P.2d at 332 (permitting a minor to consent to medical treatment because her mother was recovering from “major surgery”). Indeed, some adolescents may be dissuaded from seeking medical care if parental consent is required, “due to the sensitive nature of the minor’s medical condition or to the fact that the minor is unwilling to share with a parent the circumstances that led to the need for treatment.” Restatement of the Law, Children and the Law § 19.01

to Ease Concerns for School Staff on Non-Emergency Medical Aid, Tennessean (Apr. 8, 2025), <http://www.tennessean.com/story/news/politics/2025/04/08/tennessee-house-passes-bill-school-staff-medical-aid/82979851007/>.

19. Fran Ciardullo, *Minors and Health Care: New Law Allows Homeless Youth to Consent to Health Care*, New York Beat (Dec. 2023), at 1, https://www.barclaydamon.com/webfiles/MGMA%20New%20York%20Beat%20-%20Minors%20and%20Health%20Care%20New%20Law%20Allows%20Homeless%20Youth%20to%20Consent%20to%20Health%20Care%20-%20Fran%20Ciardullo%20-%2012_18_23%20WITH%20REPRINT%20PERMISSION.pdf.

cmt. b (Am. L. Inst., Tentative Draft No. 2, 2019).²⁰ In these circumstances, authorizing the minor to consent can “facilitat[e] access to beneficial medical treatment that the minor otherwise might not obtain,” *id.*, and allow medical providers to support the young person in bringing their family into that care.

Common law and legislation thus reflect the consensus that some situations require minor consent as a supplement to parental consent to ensure youth access to health care.²¹

20. A fifteen-year-old told researchers, “I feel like getting the parent out of the room, and then having a one on one [with doctors], . . . that would always help. Because sometimes kids . . . feel like they cannot [open up] with the parents around.” Eleanor Lustig et al., *Adolescent, Parent and Clinician Perspectives on Time Alone in Chronic Illness Visits at a Single Children’s Hospital*, 51 Child: Care, Health & Dev. E70147 (2025), <https://pmc.ncbi.nlm.nih.gov/articles/PMC12379060/pdf/CCH-51-e70147.pdf>. Another fifteen-year-old shared, “I also feel like a lot of judgement left the room” when my parents stepped out, and “I could be open and honest about how I felt.” *Id.* A sixteen-year-old stated, “[S]ome teenagers, they are actually not comfortable with their parent being in the room with them because they do not feel like they can speak their minds.” *Id.*

21. See, e.g., Illinois Senator Heather Steans’ statement in 2017 that she did not know of “any opposition” to a bill allowing some minors to consent to care by chiropractors and optometrists. Ill. S. Tran. 2017 Reg. Sess. No. 56 (May 30, 2017).

II. Minor Consent Is Essential for Youth Health and Safety.

The nationwide consensus in favor of minor consent underscores the vital interest in ensuring that young people can access essential health care.

A. Youth's Experience Proves that Minor Consent Is Invaluable and Saves Lives.

Youth across the country have explained, in their own words, how crucial it is for them to be able to consent to mental health care at times. Young people, including the below members and affiliates of amici Youth Power Project, describe this care as lifesaving.

Maddie (Texas):

I can say with certainty I am alive today because of Crisis Textline and the National Suicide Hotline. These are mental health resources I had access to as young as age eleven without parental consent. I started self-harming as early as ten years old and my suicidal thoughts followed soon after. I didn't have the vocabulary to explain what was happening inside me or ask for help—I didn't know what help looked like. . . . Having access to mental health resources remotely and without parental consent allowed me to talk out my feelings instead of hiding which [had] only intensified my emotional distress. The volunteer crisis counselors taught me valuable and lifelong grounding skills and empowered

me to problem-solve when things felt hopeless. I gained the confidence to ask my parents to speak to a therapist when I was thirteen years old. . . . My survival is entirely tied to the availability of these remote, confidential lines in my youth without the need for parental consent. . . . If I had been required to get parental consent just to text a crisis line at eleven years old, I would have chosen silence instead. I would not have reached out, and I would not be here today.

Maydeling (Florida):

When I first decided to seek mental health care, I was really scared of being misunderstood. I worried that my family might question why I wanted to seek therapy when, from the outside, it might not seem like I needed it. Because of that fear, I initially chose not to tell my family that I was actively seeking therapy. . . . At first, I was not ready to involve my family, not because I did not feel support[ed], but because I was afraid of being misunderstood. Eventually, my family became an important source of encouragement. However, I needed the opportunity to seek help on my own before I felt ready to share my experience with them. I am grateful I had that choice. Having access to care without first obtaining parental consent gave me the space to understand my needs and decide when I was ready to involve my family. If I had been required to obtain parental consent before attending therapy or seeing a psychiatrist, my fear of being misunderstood

or questioned could have prevented me from seeking help when I needed it. I cannot know exactly what would have happened.

For many young people, reaching out for mental health support can be difficult, even with supportive and accepting families.

E.S. (Virginia):

At the peak of my Obsessive Compulsive Disorder, I was getting an average of five hours of sleep, regularly staying up through the night to work on re-writing my notes—one of my most severe compulsions. . . . My grades were slipping, I was perpetually exhausted, and I could tell that I was nearing a point I could not return from. . . . If I let my disorder worsen, I knew it would end up killing me.

I am from northern Virginia . . . from a family that has always been able to live comfortably. . . . I grew up knowing that my family took mental health concerns seriously, as did my peers, and had constant exposure to the kinds of resources at my disposal if I found myself struggling mentally. Surrounded by some of the most ideal conditions a person could hope to have, I still struggled for years to speak up about my mental health struggles. . . . Asking for help is difficult as-is, and a difficult road to receiving it can be deterrent enough to stop individuals from ever pursuing it.

O.S. (Oregon):

When parental consent is required, getting support can feel less like simply asking for help and more like having to justify why I need it to the very people whose understanding matters most to me. Even when parents have good intentions, their differing perspectives on mental health can unintentionally prevent teenagers from receiving care.

Another youth explained that having space to speak with a trusted provider can make it easier for youth to involve parents in their care later on.

I.M. (Florida):

For young people, seeking mental healthcare can already require overcoming significant emotional barriers. The possibility of having to disclose deeply personal experiences to a parent before receiving care can make that process even more intimidating. Even in families where parents care deeply about their children, young people may fear being misunderstood, judged, or having their concerns minimized. My experience has taught me that privacy in healthcare is not necessarily about excluding parents. Sometimes, it is about giving young people the space to acknowledge their struggles, ask questions, and begin receiving support before they feel ready to involve their families.

When youth are not able to access the care they need, they suffer harm.

Cynthia (Tennessee):

Growing up in a rural southern community, I faced significant mental health struggles but stayed silent because I was afraid—afraid that I'd be dismissed, afraid of judgment from others, afraid that I'd further burden my parents as one underwent cancer treatment and the other worked overtime to support our family. As a legal dependent at the time, receiving mental health support required my parents' consent; due to the social stigma against mental health in both the rural South and especially within the Asian American community, I opted against seeking help because I didn't think that those around me would take my concerns seriously. . . . Every day felt like a painstaking battle, one where I knew that the help I needed was everywhere, but my access to it was non-existent. Even in school, all around me, many teachers and classmates discredited how I was feeling because, on paper, I was a high performer. As I think back to my younger self, I often find myself wondering if, had I been able to access critical mental health services earlier, what else would I have been able to do or be? A better student, a better friend, a better community member. So much potential was ripped away because I couldn't receive treatment for my mental battles. I know that I was not the only young person in Tennessee who couldn't access mental health care when I needed it, and my greatest fear is that many and more future generations of

children and youth in my home state and across the nation will continue to face the same—or harsher—obstacles to care.

Cynthia is not alone. A 2025 study surveying adolescents found that many “want[ed] mental health support but [were] unable to access it” because of family barriers.²²

B. Physicians Explain Why Even Youth With Strong Family Relationships Need Minor Consent.

Dr. Angie Devitt, an Idaho family physician for almost thirty years and past president of the IAFP, shares her experience that minor consent can bring families closer. “A lot of times I know their family and I can say, ‘If you need my help talking to your family, I will have that conversation with you in the same room.’ Teenagers sometimes need support to be able to take those steps and talk to their parents.” In these cases, mandatory parental consent deters youth from seeking mental health care. Dr. Devitt described a youth patient who was engaging in self-harm: “I had a situation where a patient was cutting. I noticed it on their arms. I asked about what was going on, and they asked if their parent would find out. When I said the parent would have access to that information, they didn’t want to talk about that.” In contrast, minor consent gives adolescents the option to confide in family physicians or pediatricians, who can, according to Dr. Devitt, “bridge

22. See Chantelle A. Roulston et al., “*My Family Won’t Let Me.*” *Adolescent-Reported Barriers to Accessing Mental Health Care*, 35 J. Rsch. on Adolescence e70013 (2025) (surveying 123 adolescents).

that . . . gap [and] talk them through discussing difficult situations with their parents.” Dr. Devitt shares, parents are “absolutely” thankful and have told her “they are happy that their children can talk to me. They know their kids can’t talk to them about everything.”

Dr. Loren Colson, another Idaho doctor practicing since 2015 who is an IAFP Executive Board member, concurs. He says, there are “so many circumstances that arise” including that the “minor is embarrassed, even if they have a good relationship with their parent, and can’t get the care they need to keep themselves healthy and safe.”

C. Youth Would Be Exposed to Serious Harm Without Minor Consent.

The importance of minor consent is further highlighted by the gravity of harm that occurs when minors cannot access health care. The experiences of youth in states that have recently enacted strict parental consent laws shows what is lost when minor consent is curtailed.

a. Youth Can Be Denied Access to Crisis Hotlines and Mental Health Care.

Strict parental consent laws deprive youth of meaningful access to crisis hotlines. After Idaho enacted S.B. 1329 in 2024 and before its amendment in 2026, the state’s 988 crisis hotline had to turn away youth callers without parental consent repeatedly.²³ A fifteen-year-old was turned away when he called for support, and

23. Guido, *supra* note 14.

another teen was reportedly hung up on during twelve distinct crises.²⁴ Moreover, as noted by the hotline’s director, most youth hang up after learning that they need parental consent to receive support because they feel unable to ask for such permission while in crisis.²⁵ These realities highlight that youth often hesitate to share suicidal thoughts with their parents, and that support from counselors can be crucial in helping the youth seek appropriate care. *See supra* Part II.B.

Preventing youth from accessing care in crises also escalates the situations. One Idaho teen turned away from the hotline during a mental health emergency was later hospitalized for suicidality.²⁶ In a hearing before Idaho lawmakers, the youth reflected, “I often think about how different that night might have been if someone had simply stayed and listened.”²⁷ By restricting youth’s access to crisis-related care, sweeping parental consent laws undermine youth’s mental wellbeing, and can deny them a lifeline in times of need.

Even routine mental health screenings, which can identify concerns before they become crises, can be restricted. As Dr. Colson describes the impact of passage of Idaho’s law requiring parental consent for most

24. Laura Guido, *988 Ended His Call. Now an Idaho Teen is Pushing for a Fix to State’s Parental Consent Law*, Idaho Capital Sun, (Feb. 18, 2026), <https://idahocapitalsun.com/2026/02/18/988-ended-his-call-now-an-idaho-teen-is-pushing-for-a-fix-to-states-parental-consent-law/>; Wilt, *supra* note 15.

25. Guido, *supra* note 14.

26. Wilt, *supra* note 15.

27. *Id.*

health care, “The mental health component is really big. Essentially all that’s gone now. It’s really made people reflect on type of care provided to minors that we didn’t even think about. Such as general counseling screening for how things are going at school, difficulties in classes, thoughts of self harm or harm to others, bullying, using alcohol/drug, safe practices if sexually active. Now [there’s] fear that we can’t do that without parental consent.” Dr. Colson also explains that many behavioral health providers in Idaho stopped providing care to minors after S.B. 1329’s enactment due to concerns that they would be accused of violating the law.

b. Children Can Be Denied Urgently Needed Care When Parents Cannot Be Reached.

Federal law requires certain hospitals to screen patients for emergencies without waiting for parental consent and to provide stabilizing treatment or an appropriate transfer when an emergency exists. But if screening finds no emergency, hospitals may wait for consent before providing further treatment.²⁸ And federal law does not reach certain doctors’ offices or independent urgent-care clinics, where a child may urgently need help. For example, in Maryland, an urgent care refused to treat a white adoptive mother’s Black daughter because she did not have guardianship documentation with her.²⁹

28. 42 U.S.C. § 1395dd(a), (b)(1) (2024); Ctrs. for Medicare & Medicaid Servs., State Operations Manual, app. V, tag A-2406/C-2406, at 38 (Rev. 191, July 19, 2019).

29. Angela Burt-Murray, *Black Child Turned Away from Urgent Care When Staff Doesn’t Believe Her Mother is White*, The Grio, (Oct. 3, 2018), <https://thegrio.com/2018/10/03/black-child-turned-away-from-urgent-care-when-staff-doesnt-believe-her-mother-is-white/>.

Dr. Crystal Pyrak, an Idaho family physician and past president of the IAFP, has witnessed firsthand the dangers of sweeping parental consent laws in urgent medical situations. Five days after Idaho passed S.B. 1329 in 2024, a teenage boy with a hornet allergy was stung at a high school soccer match. He did not have his normal EpiPen with him, and his parents were unreachable due to travel. Dr. Pyrak explained, “The [soccer] team couldn’t treat him. . . . The team docs didn’t know what they could do.” The boy was taken to urgent care by a family friend because he was developing signs of an allergic reaction, but he was turned away because they could not reach his parents to obtain consent. After four hours, the teenager was rushed to the hospital showing signs of full anaphylaxis, including lip swelling and trouble breathing, and was admitted to the ICU. Dr. Pyrak reported that the emergency could have been avoided: “If [the team doctors] didn’t have to worry about the consent process or finding a signed form, he probably could have gotten allergy medicine or an EpiPen at the field instead.”

c. Youth Can Face Delayed or Denied Access to Sexual Assault Exams.

Some parental consent laws can delay or deny youth access to sexual assault exams. Because these exams must be conducted promptly—often within 96 hours after an assault to preserve DNA evidence—any delays will inhibit crucial evidence collection and frustrate efforts to protect minor survivors.³⁰ Shortly following an assault, teenage

30. Anita Wadhvani, *Tennessee Bill Ensuring Teen Rape Victims Have Access to Sexual Assault Exams Fails*, Tennessee Lookout, (Apr. 28, 2025), <https://tennesseelookout.com/2025/04/28/tennessee-bill-ensuring-teen-rape-victims-have-access-to-sexual-assault-exams-fails/>.

victims may feel unprepared to discuss the incident with a parent, due to the shame and stigma of sexual violence. After the passage of Idaho's S.B. 1329, a sexual assault center employee reported that teenagers whose legal guardians are inaccessible often faced significant delays in getting exams.³¹ These delays can cause key evidence to disappear permanently—potentially freeing assailants while denying survivors justice.³² Denial of treatment under these circumstances may also make minors reluctant to report the crime, leaving them vulnerable to future sexual violence.³³

Strict parental consent laws can also shield assailants who are relatives or close family friends. Indeed, because over 90 percent of perpetrators are someone the survivor knows and trusts,³⁴ minors may be afraid to tell their parents about the assault when the abuser is a family member or friend. This can delay investigations and limit what examiners can collect in an exam in the short

31. Ruth Brown, *Idaho Policymakers 'Confident' Parental Rights Fix Will Come*, Idaho Reports, (June 18, 2025), <https://blog.idahoreports.idahoptv.org/2025/06/18/idaho-policymakers-confident-parental-rights-fix-will-come/>.

32. Wadhwani, *supra* note 30.

33. *Id.*

34. *About Child Sexual Abuse*, CDC, (May 16, 2024), <https://www.cdc.gov/child-abuse-neglect/about/about-child-sexual-abuse.html>. See also Ruth Brown, *Idaho's Parental Consent Law Prohibits Minors from Accessing Rape Kit Exams Without Parents*, Idaho Capital Sun, (Aug. 6, 2024), <https://idahocapitalsun.com/2024/08/06/idahos-parental-consent-law-prohibits-minors-from-accessing-rape-kit-exams-without-parents/>.

window while DNA evidence remains viable.³⁵ Delayed or denied forensic exams lead to additional medical and psychological complications for minor survivors compounding the initial violence.³⁶

d. Youth Can Be Denied Prenatal and Birth-Related Care.

Strict parental consent requirements also undermine pregnant minors' access to essential prenatal and birth-related care. When such necessary care is delayed or denied, both the youth and their pregnancy are at risk.

After enactment of S.B. 1329 in Idaho, a minor having contractions was forced to wait over two hours for a pelvic exam—which would determine if she was in active labor—because the hospital could not reach her unhoused mother; the girl's incarcerated grandmother eventually provided the consent, after she had gone without care for hours.³⁷ Before Idaho enacted H.B. 860 in 2026, re-introducing certain exceptions to parental consent for health care, Dr. Colson noted that minors in labor could not consent to their own epidural treatment and other labor-related care. He recounted frequent delays in obtaining parental

35. Brown, *supra* note 31. Responding to press inquiries about concerns over Idaho's parental consent law's applications in sexual abuse scenarios, Idaho's State House Speaker Mike Moyle remarked, "[t]here's some things there that we absolutely need to fix." Brown, *supra* note 34.

36. Lucy Robin Frank & Anne Derouin, *Delays in Sexual Assault Nurse Examiner Response Times: A Gap Analysis*, J. Emergency Nursing (July 2026).

37. Brulliard, *supra* note 15.

consent, which left pregnant minors “in a lot of pain,” but unable to “get pain control.”

Indeed, minors have been denied pain treatment during labor—classified as an “elective” treatment requiring parental consent—in other states. In Ohio, a fifteen-year-old with no family was denied epidural treatment, and the state’s family services could not send agents authorized to provide medical consent while she was in labor.³⁸ The homeless teenager could not reach a parent and ultimately went through active labor without any pain relief.³⁹

Some states’ laws also bar minors from consenting to a cesarean section (a “C-section”) unless it is an “emergency.”⁴⁰ Thus, absent parental consent, doctors must wait until the pregnant minor and baby are in a medical crisis to perform a C-section, which delays treatment and risks both their lives. Moreover, because performing a C-section without parental consent exposes providers to civil or criminal penalties, strict parental consent laws may make providers hesitant about providing C-sections even in true emergencies. Such laws make labor—an already high-risk medical event—more dangerous for pregnant minors. By restricting access to

38. Esther Honig, *Why Some Teen Moms Can’t Get the Pain Relief They Choose in Childbirth*, NPR, (Dec. 27, 2017), <https://www.npr.org/sections/health-shots/2017/12/27/573826484/why-some-teen-moms-cant-get-the-pain-relief-they-choose-in-childbirth>.

39. *Id.*

40. *Id.*

pregnancy-related care, these laws jeopardize the lives of pregnant minors and their pregnancy.

This problem does not end after a minor gives birth. Ironically, under strict parental consent laws, minors who cannot consent to their own medical care can, after delivery, consent to *any* care for their newborn. As an Idaho family physician who also practices obstetrics, Dr. Pyrak treats both young patients who have recently given birth and their babies. She recounted that after S.B. 1329, she was able to cover “all routine newborn care” with a minor patient who had recently given birth. However, Dr. Pyrak “couldn’t talk to her about her postpartum bleeding, how she was feeling, [or] postpartum depression” until the minor’s grandmother arrived and consented to that care. Dr. Colson notes that “this is especially difficult if the minor’s parents are uninvolved, and the minor has a condition like preeclampsia, which persists even after delivery.” Similarly, in Indiana, a seventeen-year-old can consent to their child’s circumcision, hearing testing, and other treatments, but cannot independently consent to an epidural.⁴¹

e. Parental Consent Requirements Can Impede STI Testing and Treatment.

Parental consent requirements can deter youth from seeking STI testing and treatment, endangering youth’s health. The consequences of missed testing may

41. Tracey A. Wilkinson, Brownsyne Tucker Edmonds, & Aaron E. Carroll, *Treat Teenage Moms Like Moms, Not Children*, N.Y. Times, (Feb. 13, 2018), <https://www.nytimes.com/2018/02/13/opinion/teenage-mothers-children.html>.

not become apparent until an infection has caused harm. Even teenagers with supportive parents may hesitate to discuss sexual health in front of them. In a national survey analyzed by the Centers for Disease Control and Prevention, 22.6 percent of sexually experienced adolescents reported that they would forgo sexual or reproductive health care because their parents might find out.⁴² For those teenagers, requiring parental involvement may not produce a family conversation; it may prevent the visit altogether.

In Idaho, Dr. Pyrak has witnessed the dangers when minors cannot access care independently. In one example, a youth patient came to her walk-in clinic several times over a period of weeks with abdominal pain. Her mother declined to allow Dr. Pyrak to speak with her daughter alone, and the youth patient did not answer when asked about her sexual history in front of her mother. On the youth's fourth visit, the minor "had a fever and [Dr. Pyrak] became more alarmed, and was finally at that point allowed to do an abdominal exam and speak with the youth alone. We found that she had an untreated chlamydia infection that had progressed to Pelvic Inflammatory Disease, which can impact a patient's fertility. If the youth had gotten testing and treatment for the chlamydia earlier, she would not have developed PID and its associated risks."

42. Jami S. Leichliter et al., Confidentiality Issues and Use of Sexually Transmitted Disease Services Among Sexually Experienced Persons Aged 15–25 Years—United States, 2013–2015, 66 *Morbidity & Mortality Wkly. Rep.* 237, 238–39 & tbl. 1 (2017), <https://www.cdc.gov/mmwr/volumes/66/wr/mm6609a1.htm>.

f. Parental Consent Requirements Can Obstruct Substance-Use Treatment.

Clinicians treating adolescents for substance-use disorders ordinarily try to involve parents. But for some teenagers, requiring notification at the outset can keep them from seeking help. During a 2024 debate over broader parental consent requirements in New Hampshire, licensed drug and alcohol counselor Jacqui Abikoff explained that some minors will seek help only if their parents will not immediately be notified. New Hampshire ultimately left in place a statute allowing minors twelve and older to seek drug-dependency treatment without parental consent.⁴³

Parental unavailability can also interrupt care already underway. At a 2023 California legislative hearing, pediatrician Jayme Congdon described a seventeen-year-old patient, “CB,” who had, with her mother’s support, begun buprenorphine treatment while hospitalized for opioid withdrawal. But before her outpatient appointment, her mother—who also had an opioid use disorder—relapsed and left home. Without parental consent, the clinicians could not continue CB’s medication. “She showed up several times without her mother,” Dr. Congdon testified, and without access to care, CB eventually relapsed.⁴⁴

43. 2024 N.H. Laws ch. 90 (establishing a committee to study minor consent and confidentiality); N.H. Rev. Stat. Ann. § 318-B:12-a (2026) (permitting specified voluntary drug-dependency treatment for minors twelve and older); N.H. Gen. Ct., Docket of S.B. 573 (2024).

44. Hearing on A.B. 816 Before the S. Comm. on the Judiciary, 2023–2024 Reg. Sess. (Cal. June 20, 2023) (testimony of Jayme Congdon, M.D., on behalf of the American Academy of Pediatrics).

g. Youth Can Be Denied Basic Health Care in School.

Sweeping parental consent laws can and have denied youth basic health care in school. Under such laws, school nurses have been unable to provide basic treatments to students who lack parental consent on file, due to confusion and fear of potential legal violations.⁴⁵ For instance, after passage of S.B. 1329, some Idaho school employees were unable to treat a student with a broken femur because they could not contact his parents.⁴⁶ In Florida, schools now must call parents to pick up injured or sick children who lack parental consent on file, and educators are prohibited from providing even bandages or ice packs to these students.⁴⁷ Likewise, a boy in Texas was sent home covered in vomit because school staff believed they could

45. Addie Hovland, *School Nurses Refuse to Give Children Band-Aids, Claim ‘Confusion’ Over New Law*, Texas Scorecard, (Sept. 5, 2025), <https://texasscorecard.com/state/school-nurses-refuse-to-give-children-band-aids-claim-confusion-over-new-law/>. Ryan Suppe, *Parental Consent for Band-Aids? Boise School District Says It’s Required Under New Law*, Idaho Ed News, (Aug. 15, 2024), <https://www.idahoednews.org/news/parental-consent-for-band-aids-boise-school-district-says-its-required-under-new-law/>.

46. Wilt, *supra* note 15.

47. *Thousands of Palm Beach County Students Can’t Receive Basic Medical Care Due to Missing Consent Forms*, WPTV, (Aug. 26, 2022), https://www.wptv.com/news/education/thousands-of-palm-beach-county-students-cant-receive-basic-medical-care-due-to-missing-consent-forms#google_vignette; see also Jordan Zakarin, *Teachers in Florida Banned from Giving Kids Band-Aids*, Progress Report, (Aug. 22, 2022), <https://www.progressreport.news/p/teachers-in-florida-banned-from-giving>.

not assist with clothing changes without parental consent under the state’s recently enacted Act of June 20, 2025, 89th Leg., R.S., Ch. 1125 (Senate Bill 12) (“S.B. 12”), which requires parental consent for providing “health services” to students.⁴⁸ School district confusion about whether basic non-emergency first aid or wellness check-ins were permitted under the law led S.B. 12’s authors to request “clear and consistent guidance” about permissible care from the Texas Education Agency.⁴⁹

Under strict parental consent laws, care for injured or sick children, which depends on a parent’s availability to provide consent, can be blocked because a parent is working or otherwise occupied. Accordingly, injured and sick children may be denied even basic care indefinitely, leaving children bleeding, in pain, and missing learning time unnecessarily.

48. Jaden Edison, *Providing Basic Care to Students Does Not Violate Texas’ Parental Consent Law, State Guidance to Schools Says*, The Texas Tribune, (Sept. 11, 2025), <https://www.texastribune.org/2025/09/11/texas-tea-sb-12-school-nurses-guidance/>.

49. Jaden Edison, *Texas’ New Parental Consent Law Leaves School Nurses Confused About Which Services They Can Provide to Students*, The Texas Tribune, (Sept. 5, 2025), <https://www.texastribune.org/2025/09/05/texas-school-nurses-students-parental-consent/>.

III. Petitioners Have No Concrete Injury Traceable to RCW § 71.34.530 That Could Give Them Standing to Challenge It.

The Constitution only extends the federal judicial power to “Cases” and “Controversies.” U.S. Const. art. III, § 2. That limit confines federal courts to redressing or preventing actual or imminent injury. *Summers v. Earth Island Inst.*, 555 U.S. 488, 492 (2009). Article III standing enforces that limit, and its core is “an essential and unchanging part of the case-or-controversy requirement” *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

Disagreement with a legislature’s decisionmaking is not, by itself, a substitute for the concrete injury Article III requires. Standing is a “bedrock constitutional requirement.” *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 378 (2024). The Court has “repeatedly held that mere offense, disagreement, or distaste does not qualify as a concrete and particularized injury under Article III.” *Nat’l Park Serv. v. Nat’l Tr. for Historic Pres. in the United States*, 609 U.S. ____ (2026) (per curiam) (slip op. at 3). Petitioners describe only their disagreement with Washington State allowing some youth to access outpatient behavioral health care; they fail to articulate any concrete injury from this law. Article III standing prevents litigants like Petitioners from litigating their displeasure with policies that do not harm them. *See, e.g., id.* (collecting cases and reiterating that genuine interest does not alone satisfy the “particular concrete injury” requirement); *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State, Inc.*, 454 U.S. 464, 485 (1982) (standing is not satisfied by “the psychological

consequence presumably produced by observation of conduct with which one disagrees . . . ”). Petitioners’ standing theories all fail because Petitioners can show no current or plausible future harm and Petitioners are not the objects of the challenged laws. Amici address three points specific to Petitioners’ challenges to RCW § 71.34.530.

First, Petitioners are not the object of RCW § 71.34.530. Petitioners contend that “all Washington parents of children ages 13-17 who would oppose ‘outpatient treatment’ for their child without parental authorization are . . . the object of RCW §71.34.530,” and would therefore have standing. Pet’rs Br. at 30. However, this Court has held that, when an alleged injury arises from the government’s regulation of someone else, standing is “substantially more difficult” to establish. *Lujan*, 504 U.S. at 562 (quoting *Allen v. Wright*, 468 U.S. 737, 758 (1984)). RCW § 71.34.530 does not regulate parents or require them to do, refrain from doing, or permit anything. It instead regulates the circumstances in which minors and treatment providers may proceed without a parent’s consent: a minor age thirteen or older “may request and receive outpatient treatment without the consent of the adolescent’s parent.” RCW § 71.34.530. The statute operates on the minor’s ability to obtain treatment and the provider’s ability to furnish it, not on the parent. That does not, of course, make parental interests irrelevant. It means only that Article III requires a parent challenging the statute to identify a concrete injury caused by it.

Second, Petitioners’ own briefing makes clear that they experience no injury from RCW § 71.34.530. Their petition presented a *single* question: “Whether

parents have standing to challenge a law or policy that deliberately displaces their decisionmaking role as to ‘gender transitions’ of their children. . . .” *See* Pet. for Writ of Cert. at i. However, RCW § 71.34.530 does not address gender-affirming medical interventions. *Id.* It is a general behavioral health statute limited to outpatient treatment. Resp. Br. 12-14.

Further, Petitioners’ Merits Brief asserts that only Parents 5A and 5B have standing to challenge RCW § 71.34.530 based on current harms. Pet’rs Br. at 44-45. But their child is now an adult, so their claims are moot. Resp. Br. 16, 21, 36. And the operative complaint does not allege that their child’s subsequent hospitalizations were outpatient treatment under RCW § 71.34.530, that 5A and 5B declined to authorize it, or that they sought information from the child’s providers. First Amended Complaint (“FAC”) ¶¶ 55-57 (Pet. App. 77a). Any alleged future harm for other Petitioners depends on the choices of independent third parties and is too speculative to support standing. Resp. Br. 41-47.

Third, Petitioners have conceded that RCW § 71.34.530 poses “zero” risk of constitutional harm to them. Washington’s law has permitted adolescents thirteen and older to obtain outpatient treatment without parental consent, in substantially similar form, since 1985. Pet. App. 5a. Petitioners’ Complaint attributes their asserted risk of constitutional harm entirely to the 2023 amendments to the shelter law, a different statute also challenged by Petitioners: “Before the... amendments, the probability of constitutional injuries here was *zero*—the threat is *entirely* due to the statute’s amendments, thus satisfying traceability. And so, holding unconstitutional

the... amendments will entirely redress the threat of injury.” FAC ¶ 148 (emphasis added).⁵⁰ By Petitioners’ own account, then, RCW § 71.34.530, in effect for nearly four decades before those amendments, offers “zero” risk of constitutional harm to them. FAC ¶ 148. Because a plaintiff must clearly allege facts establishing standing, that concession is dispositive. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016).

50. For the reasons Respondents explain, Petitioners also do not have standing to challenge the 2023 amendments. *See* Resp. Br. 30–49.

CONCLUSION

Amici urge the Court to affirm.

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APPENDIX

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Appendix 1**List of *Amici Curiae***

	Organization	Website
1.	Youth Power Project	www.youthpowerproject.org
2.	Idaho Academy of Family Physicians	www.idahofamilyphysicians.org
3.	Indiana Association of School Nurses	www.inasn.org
4.	Indiana Justice Project	www.indianajusticeproject.org
5.	Covering Kids & Families of Indiana	www.ckfindiana.org

Appendix 2

Minor Consent to Selected Health Services, by State and the District of Columbia¹

Key:  = minor may consent  = provider may treat without parental consent — = statute is silent							
No.	State	Emergency care	Sexual assault care	Substance-use care	STI care	Prenatal care	Outpatient mental health care
1	Alabama		—				
2	Alaska		—	—			—
3	Arizona					—	—
4	Arkansas		—	—			
5	California						
6	Colorado	—					 
7	Connecticut	—	—	 			
8	Delaware		—				

1. See Abigail English & Rebecca Gudeman, Nat'l Ctr. for Youth L., *Minor Consent and Confidentiality: A Compendium of State and Federal Laws* (2026) (state chapters), <https://teenhealthlaw.org/compendium>. See also *id.*, app. O, State Law Table: Minor Consent/Access for Specific Services (Aug. 2026), <https://static1.squarespace.com/static/66421681d90ded764d1347e8/t/6adbb6cf43c32c3fce449c3/1792784079338/AppendixO-StateLawTableServices-2026.pdf>.

Appendix

Key:  = minor may consent  = provider may treat without parental consent — = statute is silent							
No.	State	Emergency care	Sexual assault care	Substance-use care	STI care	Prenatal care	Outpatient mental health care
9	District of Columbia		 			 	 
10	Florida		—		 		
11	Georgia		—				—
12	Hawaii		—				
13	Idaho				—		
14	Illinois						
15	Indiana						—
16	Iowa						—
17	Kansas			 	 		—
18	Kentucky						 
19	Louisiana		—	 			
20	Maine	—	 	 			

A check indicates that a state statute either allows at least some minors to consent to some services in the category or authorizes providers to offer some services without parental consent. The chart reflects state statutes only.

Appendix

	Key:  = minor may consent  = provider may treat without parental consent — = statute is silent						
No.	State	Emergency care	Sexual assault care	Substance-use care	STI care	Prenatal care	Outpatient mental health care
21	Maryland	 					
22	Massachusetts		—		 		
23	Michigan	—	 				
24	Minnesota		—				 
25	Mississippi		—	 			
26	Missouri						—
27	Montana	 	—				
28	Nebraska		—			—	
29	Nevada		—			—	—
30	New Hampshire		—		 	—	
31	New Jersey	—					
32	New Mexico		—			 	
33	New York						
34	North Carolina		—				
35	North Dakota						—

Appendix

Key:  = minor may consent  = provider may treat without parental consent — = statute is silent							
No.	State	Emergency care	Sexual assault care	Substance-use care	STI care	Prenatal care	Outpatient mental health care
36	Ohio					—	
37	Oklahoma	 					—
38	Oregon	 	—				
39	Pennsylvania		—				
40	Rhode Island	 	—				—
41	South Carolina	 	 	 	 	 	 
42	South Dakota				 	—	—
43	Tennessee		—	 			
44	Texas						 
45	Utah						—
46	Vermont		—			—	
47	Virginia	 	—				
48	Washington		—			—	
49	West Virginia			 	 	—	—
50	Wisconsin		—	 		—	
51	Wyoming					—	—