SENATE BILL 935

J1 7lr2853
CF HB 961

By: **Senator Smith**
Introduced and read first time: February 3, 2017
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Public Health – Delegation of Health Care Decisions – Temporary Health Care Agent for Minors

FOR the purpose of authorizing the parent or legal guardian of a minor to delegate to a temporary health care agent the authority to consent to and make decisions regarding medically necessary health care treatment of the minor; requiring a certain delegation to be made on a certain medical authorization treatment form; prohibiting a parent or legal guardian from delegating to a temporary health care agent the power to make certain decisions regarding life–sustaining treatment of the minor; providing that a health care agent who treats a minor is not subject to criminal prosecution or civil liability and may not be found to have engaged in certain unprofessional conduct as a result of relying in good faith on consent given by a temporary health care agent when treating a minor; providing a suggested medical authorization treatment form; defining certain terms; and generally relating to the delegation of temporary authority to consent to health care treatment on behalf of a minor to a temporary health care agent.

BY adding to
Article – Health – General
Section 20–1801 and 20–1802 to be under the new subtitle "Subtitle 18. Temporary Health Care Agents for Minors"
Annotated Code of Maryland
(2015 Replacement Volume and 2016 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

SUBTITLE 18. TEMPORARY HEALTH CARE AGENTS FOR MINORS.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

20–1801.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "MEDICAL AUTHORIZATION TREATMENT FORM" MEANS A FORM THAT DELEGATES MEDICAL TREATMENT DECISION–MAKING AUTHORITY ON BEHALF OF A MINOR TO ANOTHER INDIVIDUAL.

(3) "TEMPORARY HEALTH CARE AGENT" MEANS AN INDIVIDUAL WHO IS AUTHORIZED BY THE PARENT OR LEGAL GUARDIAN OF A MINOR TO CONSENT TO MEDICALLY NECESSARY IMMEDIATE HEALTH CARE TREATMENT ON BEHALF OF THE MINOR.

(B) (1) SUBJECT TO SUBSECTION (C) OF THIS SECTION, THE PARENT OR LEGAL GUARDIAN OF A MINOR MAY DELEGATE TO A TEMPORARY HEALTH CARE AGENT THE AUTHORITY TO CONSENT TO AND MAKE DECISIONS REGARDING MEDICALLY NECESSARY HEALTH CARE TREATMENT OF THE MINOR.

(2) THE DELEGATION SHALL BE MADE ON A MEDICAL AUTHORIZATION TREATMENT FORM THAT:

(I) INCLUDES:

1. THE NAME OF THE MINOR;

2. THE NAME AND SIGNATURE OF A PARENT OR LEGAL GUARDIAN OF THE MINOR AND THE DATE OF THE SIGNATURE;

3. THE NAME OF ONE OR MORE TEMPORARY HEALTH CARE AGENTS; AND

4. ANY LIMITATIONS ON THE MEDICAL TREATMENT DECISION–MAKING AUTHORITY OF THE TEMPORARY HEALTH CARE AGENT, INCLUDING THE DURATION OF THE TIME OF THE AUTHORITY;

(II) EXPIRES NOT LATER THAN 90 DAYS AFTER ITS EFFECTIVE DATE; AND

(III) IS REVOCABLE AT ANY TIME.

(C) A PARENT OR LEGAL GUARDIAN OF A MINOR MAY NOT DELEGATE TO A TEMPORARY HEALTH CARE AGENT THE POWER TO MAKE DECISIONS REGARDING WITHHOLDING OR WITHDRAWING LIFE–SUSTAINING TREATMENT OF THE MINOR.

(D) A HEALTH CARE PROVIDER WHO TREATS A MINOR IS NOT SUBJECT TO CRIMINAL PROSECUTION OR CIVIL LIABILITY AND MAY NOT BE FOUND TO HAVE ENGAGED IN UNPROFESSIONAL CONDUCT BY THE APPROPRIATE LICENSING AUTHORITY AS A RESULT OF RELYING IN GOOD FAITH ON CONSENT GIVEN BY A TEMPORARY HEALTH CARE AGENT WHEN TREATING THE MINOR.

20–1802.

"MARYLAND STATUTORY FORM
MEDICAL AUTHORIZATION TREATMENT FORM
PLEASE READ CAREFULLY

SUGGESTED FORM – MEDICAL AUTHORIZATION TREATMENT FORM
MEDICAL AUTHORIZATION TREATMENT FORM

A. SELECTION OF PRIMARY TEMPORARY HEALTH CARE AGENT

I, _____, A PARENT OR LEGAL GUARDIAN OF _____ _____ (DOB:____), _____ (DOB: _____) AND _____ (DOB:_____) (INDIVIDUALLY A "MINOR" AND COLLECTIVELY, THE "MINORS"), HEREBY AUTHORIZE THE FOLLOWING INDIVIDUAL TO SERVE AS THE TEMPORARY HEALTH CARE AGENT WITH RESPECT TO THE MINOR(S):

NAME:_____

ADDRESS:_____

_____

TELEPHONE NUMBERS:_____
(HOME AND CELL)

B. SELECTION OF BACK–UP TEMPORARY HEALTH CARE AGENT (OPTIONAL; FORM VALID IF LEFT BLANK)

1. IF MY PRIMARY TEMPORARY HEALTH CARE AGENT CANNOT BE LOCATED OR CONTACTED IN TIME BASED ON THE HEALTH CARE NEEDS OF THE MINOR(S) OR FOR ANY REASON IS UNAVAILABLE, UNABLE, OR UNWILLING TO ACT AS MY TEMPORARY HEALTH CARE AGENT, THEN I SELECT THE FOLLOWING PERSON TO ACT IN THIS CAPACITY:

NAME: _____

ADDRESS: _____

_____

TELEPHONE NUMBERS: _____
(HOME AND CELL)

C. POWERS AND RIGHTS OF TEMPORARY HEALTH CARE AGENT

I AUTHORIZE MY TEMPORARY HEALTH CARE AGENT TO MAKE ALL DECISIONS WITH RESPECT TO, AND GIVE CONSENT TO, ANY AND ALL MEDICALLY NECESSARY IMMEDIATE HEALTH CARE TREATMENT FOR THE MINOR(S). NOTWITHSTANDING THE FOREGOING, IN NO EVENT SHALL THE TEMPORARY HEALTH CARE AGENT HAVE THE POWER TO MAKE DECISIONS REGARDING WITHHOLDING OR WITHDRAWING LIFE–SUSTAINING TREATMENT FOR THE MINOR.

D. HOW THE TEMPORARY HEALTH CARE AGENT IS TO DECIDE SPECIFIC ISSUES

THIS POWER IS SUBJECT TO THE FOLLOWING CONDITIONS OR LIMITATIONS: (OPTIONAL; FORM VALID IF LEFT BLANK)

_____

_____

_____

_____

E. ACCESS TO MINOR'S HEALTH INFORMATION – FEDERAL PRIVACY LAW (HIPAA) AUTHORIZATION

1. **DURING THE TIME THE TEMPORARY HEALTH CARE AGENT HAS FULL POWER TO ACT UNDER THIS DOCUMENT, THE TEMPORARY HEALTH CARE AGENT MAY REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, ORAL OR WRITTEN, REGARDING A MINOR'S PHYSICAL OR MENTAL HEALTH, INCLUDING MEDICAL AND HOSPITAL RECORDS AND OTHER PROTECTED HEALTH INFORMATION, PERTAINING TO THE MEDICALLY**

NECESSARY IMMEDIATE HEALTH CARE TREATMENT BEING SOUGHT FOR THE MINOR, AND CONSENT TO USE AND DISCLOSURE OF THIS INFORMATION.

2. FOR ALL PURPOSES RELATED TO THIS DOCUMENT, THE TEMPORARY HEALTH CARE AGENT IS THE PERSON IN INTEREST UNDER MARYLAND'S CONFIDENTIALITY OF MEDICAL RECORDS ACT AND THE PERSONAL REPRESENTATIVE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). THE TEMPORARY HEALTH CARE AGENT MAY SIGN, AS THE PERSONAL REPRESENTATIVE OF THE MINOR(S), ANY MEDICAL RECORDS RELEASE FORMS OR OTHER HIPAA–RELATED MATERIALS.

F. DURATION

THE APPOINTMENT OF THE TEMPORARY HEALTH CARE AGENT PURSUANT TO THIS MEDICAL AUTHORIZATION TREATMENT FORM SHALL BE EFFECTIVE AT 12:01 A.M. ON_____, ____, (THE "EFFECTIVE DATE") AND SHALL TERMINATE AT 11:59 P.M. ON _____, _____(THE "TERMINATION DATE") (WHICH TERMINATION DATE CANNOT BE MORE THAN 90 DAYS FROM THE EFFECTIVE DATE).

G. SIGNATURE AND WITNESSES

BY SIGNING BELOW AS PARENT/LEGAL GUARDIAN OF THE MINOR(S), I REPRESENT THAT I AM EITHER A PARENT OF THE MINOR(S) WITH THE LEGAL RIGHT TO MAKE HEALTH CARE DECISIONS FOR THE MINOR(S), OR A LEGAL GUARDIAN FOR THE MINOR(S) ACTING PURSUANT TO AN APPLICABLE COURT ORDER IN EFFECT AS OF THE DATE INDICATED BELOW, AND CONTINUING THROUGH THE TERMINATION DATE. FURTHERMORE, I INDICATE THAT I AM MENTALLY COMPETENT TO MAKE THIS MEDICAL AUTHORIZATION TREATMENT FORM AND THAT I UNDERSTAND ITS PURPOSE AND EFFECT. I ALSO UNDERSTAND THAT THIS DOCUMENT REPLACES ANY SIMILAR MEDICAL AUTHORIZATION TREATMENT FORM I MAY HAVE COMPLETED BEFORE THIS DATE.

_____ _____

(SIGNATURE OF PARENT/LEGAL GUARDIAN) **(DATE)**

ADDRESS:_____

_____

TELEPHONE NUMBERS:_____

(HOME AND CELL)

THE PARENT/LEGAL GUARDIAN SIGNED OR ACKNOWLEDGED SIGNING THIS DOCUMENT IN MY PRESENCE AND, BASED ON PERSONAL OBSERVATION, APPEARS TO BE MENTALLY COMPETENT TO MAKE THIS MEDICAL AUTHORIZATION TREATMENT FORM.

_____ _____

(SIGNATURE OF WITNESS) **(DATE)**

_____

(TELEPHONE NUMBER(S)):

_____ _____

(SIGNATURE OF WITNESS) **(DATE)**

_____

(TELEPHONE NUMBER(S)):

(NOTE: ANYONE SELECTED AS A TEMPORARY HEALTH CARE AGENT ABOVE MAY NOT BE A WITNESS. MARYLAND LAW DOES NOT REQUIRE THIS DOCUMENT TO BE NOTARIZED.)"

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2017.