



## Hawaii Notice of Non-Disclosure of Minor-Initiated Mental Health Care

Pursuant to Hawaii Rev. Stat. § 577-29, minors, 14 years of age or older, may consent to outpatient mental health services without parental or legal guardian consent, knowledge or participation, after consulting with a licensed mental health professional and there is agreement on confidentiality for minor initiated services.

<i>Notice Type (check one)</i>
<input type="checkbox"/> <b>New Non-Disclosure Agreement</b>
<input type="checkbox"/> <b>Extended Expiration Date of Non-Disclosure</b>
<input type="checkbox"/> <b>Withdrawal of Non-Disclosure Agreement</b>

### 1. Minor Information (Information About Minor Whose Records Are Being Protected)

Last Name:	First Name:	Middle Initial
Minor's Health Plan I.D. Number:	Birthdate (MM/DD/YYYY):	
Minor's Street Address:	City, State and ZIP Code:	
Mother's or Legal Guardian Last Name:	First Name:	Middle Initial:
Father's or Legal Guardian Last Name:	First Name:	Middle Initial:

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING  
YOUR NON-DISCLOSURE AUTHORIZATION.**

Attached is a signed agreement that states the minor received mental health counseling which included a discussion on confidentiality, and the minor and the licensed mental health professional agree that the minor's mental health services should not be disclosed to the minor's parents/legal guardian for the period of time specified in the agreement.

is hereby notifying the minor's health plan that the minor's self-initiated mental health services should not be disclosed to the minor's parent(s)/legal guardian through the health plan's explanation of benefits or by any other means. Non-disclosure is temporary and begins and ends according to the effective and expiration dates in the agreement with the minor. Should the non-disclosure agreement be withdrawn, or should the nondisclosure be extended, the mental health provider will notify the health plan with an updated agreement.

**PLEASE ATTACH THIS NOTICE TO THE NON-DISCLOSURE AGREEMENT  
BEFORE SENDING THE FORM TO AETNA.**



# Hawaii Non-Disclosure of Minor-Initiated Mental Health Care Agreement

To keep minor's initiated outpatient mental health services confidential pursuant to HI Rev. Stat. § 577-29, complete and return this form to the below address.

Return this form to: **Address:** Aetna HIPAA Member Rights Team, P.O. Box 14079, Lexington, KY 40512-4079  
**Email:** [HIPAAfulfillment@aetna.com](mailto:HIPAAfulfillment@aetna.com) OR **Fax:** (859) 280-1272. Be sure to send secure.

## Minor's Statement:

I am a minor and am 14 years of age or older. I am seeking mental health services without consent, knowledge, or participation of my parent/legal guardian. My mental health care provider and I had a discussion and agreed, that it is in my best interests not to involve my parents in my mental health treatment, at this time. I am requesting confidentiality of my minor-initiated mental health service information and that this information not be disclosed to my parent(s)/legal guardian through my health plan's explanation of benefits or by any other means. I understand that I or my therapist may withdraw this agreement and this agreement is temporary as specified by my therapist.

## 1. Minor's Signature REQUIRED:

Signature of Minor ( <u>Required</u> ):	Date:
Printed Name:	Date of Birth ( <i>MM/DD/YYYY</i> ):

## 2. Licensed Mental Health Professional's Signature REQUIRED:

Type of Service:	Date of Service:
Signature of Licensed Mental Health Professional ( <u>Required</u> ):	Date:
Printed Name:	

## 3. Agency or Business Information:

Name of Agency/Business:	
Phone Number:	NPI#
Name of Mental Health Professional who conducted the "minor-initiated" initial assessment (if applicable):	

## 4. To be completed and dates initialed by the minor's therapist:

Nondisclosure Effective Date:		Nondisclosure Expiration Date:	
Extension of Nondisclosure Start Date:		Extension of Nondisclosure Expiration Date:	
Agreement Withdrawal Date:			

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.*

TTY: 711

<b>English</b>	<b>To access language services at no cost to you, call the number on your ID card.</b>
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.