minors' consent to contraception, and another 19 states allow certain classes of minors to consent to contraception.[33] The AAP encourages pediatricians to become familiar with relevant minor consent laws in their jurisdiction. With the rapid changes in state laws after the US Supreme Court *Dobbs* decision, the AAP State Advocacy team can provide pediatricians with an update on their state's legal landscape and opportunities for advocacy by pediatricians at the state level (stgov@aap.org). For states without specific state laws, federal statutes (eg, Title X and Medicaid) and federal case law may provide some support for minor confidentiality and consent for contraception.[22,34,35] For example, Title X of the federal Public Health Services Act (42 USC §300–300a-6 [1970]) requires family planning clinics funded by Title X to provide confidential services for minors. (For a detailed discussion, see *State Minor Consent Laws*, 3rd Edition.[35])

The Health Insurance Portability and Accountability Act (HIPAA [Pub L No. 104–191, 1996]) also addresses minor confidentiality. Under HIPAA, a pediatrician may protect minor confidentiality when the minor can legally consent for contraceptive care in their jurisdiction or when the parent/caregiver agrees to confidentiality.[36] HIPAA additionally states that even when there is no applicable law, providers may exercise professional judgment to maintain confidentiality (with the reasoning documented in the health record).[36] An office policy that explicitly describes confidential services and a practice habit to discuss confidentiality policies with both parents/caregivers and adolescents can assist pediatricians with HIPAA compliance.

Insurance billing and explanations of benefits (EOBs), electronic health records (EHRs), and patient online portals create system-level threats to the confidentiality of visits, visit content, laboratory test results, and payment for contraceptive care.[37] The 21st Century Cures Act has amplified these threats to confidentiality. A common response to provisions prohibiting information blocking is to make EHR notes accessible through the patient portal, yet parent/caregiver access to patient portals is common, with adolescent portals frequently registered with parent/caregiver emails.[37–39] The AAP policy statement on health information technology provides additional discussion of EHRs and confidentiality.[40–42]

On a more pragmatic level, although some parents/caregivers may not want to honor teen confidentiality, data show that many parents/caregivers are supportive of both confidentiality and adolescent time alone with providers to address sexual and reproductive health care.[43–45] As a best practice, pediatricians can offer contraception as a confidential service when legally able to do so, allowing the adolescent the choice to involve parents, caregivers, or another trusted adult. To decrease parent/caregiver and adolescent reluctance about time alone with a provider, pediatricians can introduce confidentiality and time alone during early adolescence.[46] When adolescents present for contraception care together with a parent/caregiver, the parent/caregiver may benefit from anticipatory guidance and educational materials from pediatricians regarding confidentiality, adolescent development, emerging autonomy for decision making, and general contraceptive care approaches.

ADOLESCENT-CENTERED COUNSELING

The AAP recommends the use of a sexual and reproductive health equity-informed and adolescent-centered approach to counseling about contraception (see companion clinical report[3]). This approach applies shared decision making and person-centered care principles to center adolescents' priorities and helps them choose a method that best fits their goals, preferences, and life circumstances.[7,8,47–49] Equity-informed, adolescent-centered counseling involves reflection upon one's own biases, assessing the adolescent's stated goals and preferences, assessing the adolescent's developmental needs and contextual barriers and facilitators, presenting method options based on the adolescent's stated preferences and developmental needs, and addressing any barriers to method choice and continuation (Table 3). This is a departure from counseling approaches based entirely on efficacy. The pediatrician starts with the adolescent's goals, preferences, and needs then provides method-specific information and counseling to enable the adolescent to meet those goals. For adolescents for whom pregnancy prevention is their most important goal, a highly effective LARC could be recommended. For adolescents for whom it is very important to have no hormones and no devices, a barrier method supported by pediatrician education and counseling could be how they meet their goals. On a practical note, adolescents' buy-in is critical to contraceptive use, and a less-effective method that is consistently and correctly used may provide better pregnancy protection than a more effective method that is discontinued.

CONTRACEPTIVE METHODS

Within a sexual and reproductive health equity framework, almost all forms of reversible contraception are available to adolescents. Therefore, it is important that pediatricians are familiar with the range of contraceptive methods, including LARC methods, progestin-only and combined hormonal methods, barrier methods, and emergency contraception. These options are described in detail in the method-specific policy statements from the AAP on LARCs,[50] barrier methods,[51] and emergency contraception,[52] as well as in the companion clinical report to this policy statement.[3] The update provides clinical information about additional progestin-only methods, combined hormonal contraceptive methods (pills, patches, rings), and barrier methods. Methods are listed by effectiveness in Table 4. When an adolescent expresses a preference for a LARC method, but a provider is unable to provide the same-day LARC method