

HB 822: New Idaho Law On Pediatric Sexual and Social Transitioning

BY KIM C. STANGER

Idaho’s new Pediatric Secretive Transitions Parental Rights Act, Idaho Code § 32-1016, takes effect July 1, 2026. Its purpose is to “prohibit any health care provider or educational institution from facilitating a pediatric sex transition or social transition without informing and obtaining informed consent from a minor child’s parents or guardians.”¹ Violations may result in lawsuits for damages, civil fines of up to \$100,000, and adverse licensure action. Although perhaps well-intentioned, § 32-1016 is another worrisome example of a poorly written bill enacted without sufficient vetting, refinement, or consideration of the problems that covered entities and courts will face in its application.

1. Applicability.

a. Covered Entities. The statute applies to “covered entities,” which is defined as “a primary or secondary educational institution,² a child care provider,³ or a medical, behavioral, or mental health care provider.”⁴ I will focus only on providers. “Health care provider” is not defined in this statute, but the preceding statute defines “health care provider” broadly as:

- (i) A physician, health care practitioner, or other individual licensed, accredited, or certified to perform health care services or provide counseling consistent with state law, or any agent or third-party representative thereof; or
- (ii) A health care facility or its agent.⁵

¹ I.C. § 32-1016(3)

² Note that the statute applies to a “primary or secondary educational institution,” not necessarily individual teachers and school employees. (I.C. § 32-1016(4)(c)), emphasis added; *see also id.* at § 32-1016(3). This suggests that it may not apply to or subject individual teachers and other school personnel to personal liability for violations.

³ “Child care provider” is not defined in the statute. Presumably it would apply to licensed daycare providers, but does it also apply to grandparents or other family members who might temporarily care for a child? Babysitters? Foster parents? Others? Such individuals may be considered “child care providers” under other Idaho statutes or regulations. (*See, e.g.*, IDAPA 16.06.12).

⁴ I.C. § 32-1016(4)(c).

⁵ I.C. § 32-1015(1)(b).

b. Unemancipated Minors. The statute only applies to transitioning of a “child”, which is defined as “an individual who is less than eighteen (18) years of age who is not married or legally emancipated.”⁶ It is not clear what is meant by “legally emancipated.” Does this section mean that only those minors who are married or have been declared by a court to be emancipated are considered “emancipated,”⁷ or does it apply to other emancipating events identified in statute or Idaho case law such as minors serving in the armed forces⁸ or minors who are self-supporting?⁹ Because marriage itself is typically considered an emancipating event in Idaho, the fact that the statute lists marriage separately from “legally emancipated” might suggest “legally emancipated” refers to situations in which a court has determined the child to be emancipated. If so, that is a more restricted view of emancipation than exists elsewhere in Idaho law.

c. Transitioning. The statute generally applies to sex transition procedures and social transitioning of unemancipated minors. “Sex transition procedure” is defined as a practice prohibited by I.C. § 18-1506C, *i.e.*,

- (a) Performing surgeries that sterilize or mutilate, or artificially construct tissue with the appearance of genitalia that differs from the child’s biological sex, including castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, clitoroplasty, vaginoplasty, vulvoplasty, ovariectomy, or reconstruction of the fixed part of the urethra with or without metoidioplasty, phalloplasty, scrotoplasty, or the implantation of erection or testicular prostheses;
- (b) Performing a mastectomy;
- (c) Administering or supplying the following medications that induce profound morphologic changes in the genitals of a child or induce transient or permanent infertility:
 - (i) Puberty-blocking medication to stop or delay normal puberty;
 - (ii) Supraphysiological doses of testosterone to a female; or
 - (iii) Supraphysiological doses of estrogen to a male; or
- (d) Removing any otherwise healthy or nondiseased body part or tissue.¹⁰

6 I.C. § 32-1016(4)(b).

7 *See, e.g.*, I.C. § 16-2403(1), defining “child” as “an individual less than eighteen (18) years of age and not emancipated by either marriage or legal proceeding.”

8 *See, e.g.*, I.C. § 18-604(3).

9 *See, e.g.*, I.C. §§ 66-402(6) and 32-104; *see also Ireland v. Ireland*, 123 Idaho 955, 855 P.2d 40 (1993), and *Embree v. Embree*, 85 Idaho 443, 380 P.2d 216 (1963).

10 I.C. §§ 32-1016(4)(d) and 18-1506C(3).

“Social transition” means

the process by which an individual goes from identifying with and living as a gender that corresponds to the individual’s sex to identifying with and living as a gender different from the individual’s sex and may involve social, legal, or physical changes, including adopting a name, pronouns, appearance, or dress that does not correspond to the individual’s sex.¹¹

2. Requirements. The statute imposes the following prohibitions or requirements on health care providers and other covered entities.

a. Withholding Information. Per the statute, “[a] covered entity shall not withhold information from a child’s parent or guardian related to the child’s expressed interest in or desire for sex transition procedures.”¹² It is not entirely clear what “withholding” means, *i.e.*, whether it requires that covered entities proactively disclose information to a parent or whether it only requires disclosure if requested by the parent. The latter interpretation is likely more reasonable for at least two reasons:

First, such an interpretation would be consistent with the preceding statute, § 32-1015, which states that, with very limited exceptions,¹³

No health care provider or governmental entity shall deny a minor child’s parent access to health information that is:

- (a) In such health care provider’s or governmental entity’s control; and
- (b) Requested by the minor child’s parent.¹⁴

Second, if the legislature intended to require that covered entities proactively disclose information without a parent’s request, the legislature knew how to require such as shown by § 32-1016(6), discussed below.

Like the parental access law in § 32-1015(6), § 32-1016(7) may be preempted by HIPAA in certain situations.

¹¹ I.C. § 32-1016(4)(e).

¹² I.C. § 32-1016(5).

¹³ It is not clear how § 32-1016(6) interacts with § 32-1015(7), which generally allows a provider to withhold information from a parent if:

- (a) The parent’s access to the requested health information is prohibited by a court order; or
- (b) The health information is a record that relates to physical abuse, abandonment, or neglect by the parent, as provided in [I.C. §] 33-6001(3)..., or
- (c) The parent is a subject of an investigation related to a crime committed against the child, and a law enforcement officer requests that the information not be released to the parent.

¹⁴ I.C. § 32-1015(6), emphasis added.

For example, HIPAA states that, “[n]otwithstanding a State law ... to the contrary,” a covered entity may decline to disclose information to a parent if both of the following apply:

- (A) The covered entity has a reasonable belief that any of the following is true:
 - (1) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person.
 - (2) Treating [the parent] as the personal representative could endanger the individual.
- (B) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual’s personal representative.¹⁵

For further discussion about possible HIPAA preemption, see our discussion at <https://www.hollandhart.com/idahos-new-parental-access-law-v-hipaa>.

b. Notifying Parents. In contrast to § 32-1016(5), § 32-1016(6) requires covered entities to notify parents proactively in the following circumstance:

A covered entity shall notify a minor student’s parent within seventy-two (72) hours of receiving any request by the minor student to participate in or facilitate the social transition of the minor student, including any request by the minor student to:

- (a) Be referred to by pronouns or titles that do not correspond to the minor student’s biological sex;
- (b) Be referred to using names other than the minor student’s legal name, or a nickname or derivative thereof, either in school records or otherwise;
- (c) Use restrooms, locker rooms, changing rooms, or overnight lodging designated for the opposite biological sex; or
- (d) Participate on an athletic team or any other sex-separated school activity designated for the opposite sex.¹⁶

Again, the language chosen by the legislature is problematic for several reasons.

First, it is not clear whether this section applies to healthcare providers. By its express terms, § 32-1016(6) applies to all covered entities, which includes providers. On the other hand, the rest of the subsection appears to be focused on social transitioning in the educational context, not healthcare context. It applies to requests by a “minor student,” not a minor patient, a minor generally, or “child,” which is the defined term generally

¹⁵ 45 C.F.R. § 164.502(g)(5).

¹⁶ I.C. § 32-1016(6).

used in the statute to refer to unemancipated minors. Limiting the notice requirement to minor “students” focuses on the relationship between a minor and an educational institution; a healthcare provider generally would not have a “student” relationship with a minor and, in some cases, may not even know if the minor is a student. Similarly, the examples in (a) through (d) largely relate or refer to school-type activities. It is much more likely that they would arise in the school context than in a healthcare context. The examples specifically refer to “school records” (not healthcare records), and “school activity” (not healthcare activity). Given the legislature’s use of these education-focused terms, providers have a fair argument that the notice requirement is not intended to apply to them, but there are no guarantees that a court, the Attorney General, or a licensing agency would see it that way.

Second, while not entirely clear, the examples described in subsections (a) through (d) are probably illustrative only, not exclusive. In other words, the covered entity likely must notify the parents of any request by the minor student to “participate in or facilitate” the minor’s social transitioning. As described above, the term “social transition” is very broad, including but presumably not limited to “adopting a name, pronouns, appearance, or dress that does not correspond to the individual’s sex.”¹⁷ That is not an objective test; whether names, appearance or dress “correspond to a specific sex” is heavily dependent on the interpreting person’s experience and culture. In some cases, it may be difficult for covered entities to determine whether a student’s request is related to “social transitioning” or not. For example, what if a female student Alexandra shortens her name to Alex, or Charlene prefers to be called Charlie, or Samantha is called Sam? What if girls on the lacrosse team ask to wear shorts rather than traditional lacrosse skirts? Or if a boy on the football team likes to wear long hair? In these marginal cases, how is a covered entity expected to know when a minor’s action is motivated by social transitioning or is merely a personal preference or fashion choice? As written, covered entities may be exposed to liability and/or penalized simply because a parent, jury, the Attorney General, or a licensing agency has a different view of which names, appearance or dress correspond or should correspond to an individual’s sex.

Similarly, “facilitate” and “participate” are vague and/or very broad terms. As discussed below in the context of “aiding and abetting”, it may be difficult for a covered entity to know if and when they are being asked to “facilitate” or “participate” in social transitioning as opposed to simply respecting a minor’s preferences concerning their name, style or fashion. And to make matters worse, the statute does not expressly condition liability on a covered entity’s improper intent or knowledge.¹⁸ As written, healthcare providers and other covered entities may be penalized even if they had no knowledge of a minor’s desire or efforts to socially transition or improper intent to facilitate or participate in any transition. Stated another way, they can be liable for unwittingly or unknowingly facilitating or participating in the minor’s social transitioning.

In short, how can it be fair to subject covered entities to penalties for failing to give notice based on such broad and ambiguous language and/or subjective factors when the statute does not even require improper

¹⁷ I.C. § 32-1016(4)(e).

¹⁸ Section 32-1016(12) does allow the Attorney General to consider the “state of mind of the violator” when assessing penalties, but that does not necessarily require intent to establish a violation; instead, it merely considers intent when assessing the amount of the penalty.

intent before subjecting the covered entity to a lawsuit, damages, civil penalties and/or loss of license? For at least these reasons, the notice requirement is troubling and may be difficult for covered entities to navigate, especially in the murky gray areas created by the law.

c. No Aiding and Abetting Transitions. Under the statute, “[a] covered entity shall not aid or abet a child’s efforts to obtain sex transition procedures.”¹⁹ This section builds on I.C. § 18-1506C, Idaho’s criminal statute that prohibits healthcare professionals from performing sex transition procedures on minors, by creating a private cause of action against a healthcare provider or other covered entity for aiding and abetting a sex transition procedure. By doing so, the legislature authorizes private enforcement of the criminal prohibition and presumably reduces the applicable burden of proof from “beyond a reasonable doubt” to a “preponderance of the evidence” standard, thereby increasing the risk to healthcare providers.

Section 32-1016(7) also expands the prohibition to social transitioning, *i.e.*, “[a] covered entity shall not aid or abet a child’s efforts to social transition without first obtaining written consent from the child’s parent.”²⁰

The main problem for providers and other covered entities under both of these sections is determining what constitutes “aiding and abetting.” As with other key terms, these terms are not defined in the statute. In such cases, an Idaho court would usually look to other Idaho statutes or cases for guidance.²¹ In the criminal context, “aiding and abetting” is relatively well understood and generally means that the person

intentionally aids, assists, facilitates, promotes, encourages, counsels, solicits, invites, helps or hires another to commit a crime with intent to promote or assist in its commission.... Mere presence at, acquiescence in, or silent consent to, the planning or commission of a crime is not [in the absence of a duty to act] sufficient to make one an accomplice.”²²

The commentary accompanying the jury instruction states,

Mere knowledge of a crime and assent to or acquiescence in its commission does not give rise to [aiding and abetting] liability, and the failure to disclose the occurrence of a crime to authorities is not sufficient to constitute aiding and abetting.²³

¹⁹ I.C. § 32-1016(8).

²⁰ I.C. § 32-1016(7).

²¹ Courts generally presume that when the legislature borrows a legal term of art without defining it, it intends the term to carry its established legal meaning. (*See Verska v. Saint Alphonsus Reg’l Med. Ctr.*, 151 Idaho 889, 893, 265 P.3d 502, 506 (2011)).

²² ICJI 311.

²³ *Id.*, citing *State v. Randles*, 117 Idaho 344, 787 P.2d 1152 (1990), *overruled on other grounds*, *State v. Humphreys*, 134 Idaho 657, 8 P.3d 652 (2000)).

Transposing criminal concepts applicable to aiding and abetting into the civil liability context of § 32-1016, a court would likely require more than a covered entity's mere passive awareness; instead, there must be some improper intent to achieve the prohibited end. In the criminal context, a healthcare provider who simply uses a student's preferred pronouns without more might argue they lacked the requisite facilitative intent, while a therapist who actively coaches a student on how to socially transition without parental knowledge likely crosses the line. Similarly, a healthcare provider who refers a patient to a gender clinic, prescribes puberty blockers, or provides supportive counseling explicitly directed toward transition is exposed to liability.

With that said, the traditional concept of "aid and abet" seems very similar to the terms "facilitate and participate" as used in I.C. § 32-1016(6). As discussed above, in § 32-1016(6), the legislature seems to have declared that complying with a minor student's request in the following situations (among others) would amount to "participating in or facilitating" the student's social transitioning and, hence, may constitute "aiding and abetting" regardless of intent:

- (a) [Referring to the minor student] by pronouns or titles that do not correspond to the minor student's biological sex;
- (b) [U]sing names other than the minor student's legal name, or a nickname or derivative thereof, either in school records or otherwise;
- (c) [Allowing the minor to] [u]se restrooms, locker rooms, changing rooms, or overnight lodging designated for the opposite biological sex; or
- (d) [Facilitating the minor's participation] on an athletic team or any other sex-separated school activity designated for the opposite sex.²⁴

Thus, "aiding and abetting" under § 32-1016(7) and (8) may be applied more broadly than criminal aiding and abetting, and may not even require proof of bad intent by the covered entity. I doubt the legislature intended that result, but that is the practical problem that comes with trying to interpret or apply an overly broad, imprecise statute.

3. Penalties for Violation. Covered entities who violate the statute are subject to severe consequences:

a. Civil Lawsuit. Continuing the legislature's recent trend of enforcing statutes through private causes of action, the new law authorizes "the parent or guardian of a child subjected to sex transition procedures or social transitions" (*i.e.*, an "aggrieved person" as defined in I.C. § 32-1016(4)(a)), to sue covered entities:

- (9) An aggrieved person may commence an action at law or equity in a court of competent jurisdiction against a covered entity for violations of this section.
- (10) If an aggrieved person proves that a covered entity violated the provisions of this section, such aggrieved person is entitled to recover:

²⁴ I.C. § 32-1016(6).

- (a) Declaratory relief;
- (b) Injunctive relief;
- (c) Compensatory damages; and
- (d) Reasonable costs and attorney’s fees as allowed by statute or court

rule.²⁵

Although the legislature adopted a 2-year statute of limitations for other civil lawsuits under the Idaho Parental Right Act, I.C. § 32-1010 *et seq.*, the legislature failed to include § 32-1016 in the section adopting the 2-year limitation.²⁶

It may be difficult to defend against a suit by a disgruntled or activist parent given the broad and ambiguous terms in the statute. Even if a provider were to ultimately prevail, the provider still faces the costs, disruption, and negative perceptions caused by the suit, which costs may not be covered by available insurance or negative consequences redressed by a defense verdict.

b. Attorney General Action. In addition to civil lawsuits by parents and guardians,

the attorney general may seek, and a court may award, civil penalties of up to one hundred thousand dollars (\$100,000) against a covered entity for violation of this section. Such civil penalties shall be proportionate to the violation as determined by the court based on the facts and circumstances of the violation, including the seriousness of the violation, the state of mind of the violator, and the damages actually caused by the violation of this section.²⁷

The attorney general may also sue to obtain a writ of mandamus compelling covered entities to comply with the statute.²⁸

c. Adverse Licensure Actions. Finally, “[a] licensing board is authorized to discipline a covered entity that has been referred to it pursuant to this subsection in a manner that it deems appropriate for a violation of this section.”²⁹

4. Possible Challenges. The absence of statutory definitions, use of vague and subjective standards, absence of any express intent requirement, and expansion beyond the traditional understanding of “aiding

²⁵ I.C. §§ 32-1016(9)-(10).

²⁶ I.C. § 32-1013(6), as amended effective March 31, 2026.

²⁷ I.C. § 32-1016(12).

²⁸ I.C. § 32-1016(14).

²⁹ I.C. § 32-1016(13).

and abetting” may raise significant constitutional concerns. Under both the Idaho and federal constitutions, a statute must provide fair notice of the conduct it prohibits and contain sufficient standards to prevent arbitrary enforcement. Both concerns would seem to apply to § 32-1016. The statute may also impermissibly limit or chill a covered entity’s free speech, including the right if not obligation to advise patients of treatment alternatives as part of the provider’s statutory obligation to obtain informed consent.³⁰ The statute might be subject to an equal protection argument by unjustifiably targeting certain entities. And the legislature may have impermissibly delegated enforcement to private citizens, which is especially problematic given the breadth and ambiguities in the statute. I would anticipate that the statute will be challenged on these or other grounds, but those are decisions for the courts. Until we receive a ruling or more clear guidance, healthcare providers and other covered entities are left to guess at where the line for liability will be drawn with significant exposure if they guess wrong or if a parent, the Attorney General, and/or licensing agency decides to make them a test case for defining the limits.

³⁰ See, e.g., I.C. § 39-4506.

Conclusion. As with other recent statutes reinforcing parental rights, I.C. § 32-1016 may be well-intentioned but is poorly written and raises a host of concerns for providers and other covered entities struggling to comply. The statute’s broad and ambiguous language, absence of clear intent requirements, and expansion beyond traditional legal concepts create significant uncertainty for healthcare providers. While most providers will likely not be involved in sex transition procedures or social transition situations, those who may encounter these issues — including mental and behavioral health providers, pediatricians, and other primary care providers — face real exposure if they inadvertently cross the line into aiding, abetting, facilitating, or participating in any sexual or social transitioning without the parents’ knowledge and consent. Given the subjective nature of many of the statute’s standards, the risk of liability is real even for providers acting in good faith.

Until authoritative guidance is issued or the courts provide clarification, healthcare providers dealing with minors in situations in which sex or social transitioning may be raised should take the following practical steps to minimize their exposure.

1. Review and update policies and train staff before July 1, 2026. Among other things, policies should explain the rules, relevant definitions, and address:

- How to recognize red flag situations, including requests for social transitioning or sex transition procedures.
- How to respond when a minor patient raises issues related to gender identity, preferred pronouns, preferred names, or social transitioning.
- How and when parental notification and/or consent will be provided or obtained.
- How to document relevant interactions with minor patients.

2. Obtain parental consent before facilitating, participating in, aiding or abetting social transitioning, including but not limited to using pronouns or names associated with the opposite sex or otherwise accommodating a minor's expressed gender identity. To avoid disputes over the scope of the consent, the consent should be written and specific to the circumstances, including perhaps describing authorized actions. Alternatively, a provider might seek a blanket consent under I.C. § 32-1015. For example, providers might consider incorporating into their standard intake paperwork a blanket consent form that satisfies the specific requirements in § 32-1015(4)(a)(i) and:

- Informs parents of the requirements of or expressly references I.C. § 32-1016.
- States that the provider may encounter situations in which a minor patient expresses interest in or requests participation in social transitioning.
- Provides advance written parental consent for relevant activities or accommodations (including but not limited to the use of preferred names or pronouns during treatment) if the parent chooses to grant such consent.

Providers who choose to rely on a blanket consent should understand the risks, however. While I think a blanket consent would likely be upheld given the language in § 32-1015, parents may withdraw the consent at any time. In addition, the parents may dispute the scope of the consent. Accordingly, it would be safer to obtain specific written parental consent for the requested activities.

3. Provide timely parental notification of requests to facilitate or participate in social transitioning unless and until we receive contrary guidance from a court. The notice should be:

- Provided to the parent or legal guardian with authority to make healthcare decisions for the minor.
- Documented in the patient's medical record, including the date, time, and method of notification and the identity of the person notified; and

I think it is likely that parents could waive the notice requirement in advance if such waiver were sufficiently informed and documented, but the statute does not expressly address such a waiver.

4. Respond carefully to a minor's request to facilitate or participate in social transitioning or sex transition procedures. The request itself will trigger the notice requirement, and facilitating or accommodating the request without parental consent will expose the provider to liability. The provider should:

- Avoid using preferred pronouns, names or taking other action that could be construed as facilitating or participating in social transitioning without parental consent.
- Explain to minor patients that the law limits the provider's ability to participate in social transitioning without parental knowledge and consent and, accordingly, the provider cannot and will not accommodate the request without parental notice and consent. In addition, the provider should

warn the patient that the patient's request itself may trigger the obligation to notify the parent.

- Obtain parental consent before accommodating a request for activity that may be construed as social transitioning.
- Document the response in the patient's record.

5. Respond appropriately to requests for sex transition procedures. The statute's prohibition on aiding and abetting sex transition procedures is broader than the existing criminal prohibition in I.C. § 18-1506C. Providers should:

- Refrain from performing, referring for, or prescribing medications related to sex transition procedures for minor patients as defined in the statute unless a statutory exception exists.
- Be cautious about providing referrals to gender clinics or other providers who perform sex transition procedures, as such referrals could potentially be construed as aiding and abetting.
- Consult with legal counsel before providing any services that could be construed as facilitating a sex transition procedure.
- Document their clinical reasoning and any discussions with patients and parents in the patient's record.

6. Monitor developments, including any court decisions, Attorney General guidance, or legislative amendments that may affect their obligations.

For more information, please contact Kim Stanger.



KIM STANGER

Partner
208.383.3913
[Link to Bio](#)

This publication is designed to provide general information on pertinent legal topics. The statements made are provided for educational purposes only. They do not constitute legal or financial advice nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the author. This publication is not intended to create an attorney-client relationship between you and Holland & Hart LLP. Substantive changes in the law subsequent to the date of this publication might affect the analysis or commentary. Similarly, the analysis may differ depending on the jurisdiction or circumstances. If you have specific questions as to the application of the law to your activities, you should seek the advice of your legal counsel.