Consent for Lactation Consultation

I give my consent for the lactation consultant to work with me and my baby during this consultation for my breastfeeding problem/concern. This consent is for face-to-face visits and all follow-up contacts; it includes phone conversations, and information sent via the Internet, fax or regular mail.

I understand that a lactation consultation may involve:

- touching my breasts and/or nipples for the purposes of assessment;
- inserting gloved fingers into my baby's mouth to assess suck and oral cavity;
- observation of a breastfeed, and suggestions to enhance latch or position;
- demonstration of the use of equipment or supplies that may be recommended, and
- demonstration of techniques designed to improve breastfeeding.

I give my consent for the lactation consultant to contact my baby's and my primary health care provider with a report of our consultation, as the ethics of her profession require, and to consult with them in any way she deems appropriate. I agree that she may discuss my case and forward my contact information to a breastfeeding support group counselor.

I give my consent for the lactation consultant to release pertinent information to my insurance company, as necessary.

I give my consent for the lactation consultant to use clinical information obtained during our sessions for education of other health care providers and mothers about lactation. My baby and I won't be identified in any way, but aspects of our situation might be described and discussed.

I give permission for photographs and recordings to be made, of both me and my baby, for charting and clinical education purposes. If the photographs are shared in a clinical or educational context, identifying features or information will not be shown.

I understand that total payment is expected at the conclusion of the consultation. I will receive paperwork to submit to my insurance company for consideration of reimbursement.

I understand that for this lactation consultation and all follow-up, the lactation consultant will protect the privacy of my personal health information as required by the Code of Professional Conduct of the International Board of Lactation Consultant Examiners, the IBLCE Scope of Practice for IBCLCs, the Standards of Practice of the International Lactation Consultant Association, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have received a copy of the Notice of Privacy Practices of the lactation consultant.

____ / ________________

If Mom agrees (consents), signature here — Date

____ / ________________

Lactation Consultant signature here — Date

Consent form
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