Kiran Hahn, RN, IBCLC
Helina Teshome RN, IBCLC

"Commited to helping you achive your breastfeeding goals!"

Consent for Lactation Consultant Services

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

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;
- 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 understand a partial or follow-up visit is sometimes necessary. I will be responsible for informing the lactation consultant of changes I feel are necessary in the care plan at the time of the visit or during the course of follow-up communications. Phone contact during the time following the lactation visit is crucial and considered an extension of this visit. I understand I will be given a phone number to call to report progress or to communicate continued problems or concerns. **I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.**

I hereby authorize the lactation consultant to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, referring lay breastfeeding counselor, and/or our insurance company upon request. I understand the lactation consultant may contact my physician or my child's physician if the lactation consultant feels it is necessary to consult with the physician.

I understand this practice accepts only **fee for service at time of service.** It is my responsibility to pursue reimbursement for lactation services from my insurance company. This practice does no billing for insurance reimbursement and is not a provider on any insurance plan. Reimbursement is not guaranteed, but filing is suggested.

I give permission for information, photos and/or videos of my lactation visit to be used in lactation articles or studies for professional education. 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. I won't be identified in any way, but aspects of my situation might be described and discussed.

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 Ethics of the International Board of Lactation Consultant Examiners, the Standards of Practice of the International Lactation Consultant Association, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Signature of Mother Date

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Signature of IBCLC Date

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