Consent to Lactation Consultation and receipt of HIPAA Privacy Practices

I agree that this consent remains active for each and all consults with Ruth Daly, RN, IBCLC, at Harmony Lactation, and I may not be required to sign a consent at each consult. However, I or Harmony Lactation, may choose to end our Lactation Consultant relationship at any time.

I understand that my lactation consultation may involve the following and I give permission for my Consultant to proceed with the following:

- entering my home.
- touching and assessing both myself and my baby.
- touching my breasts and/or nipples for the purpose of assessment and assistance.
- placing a gloved finger into my baby's mouth to assess oral structure and function.
- observing a breastfeeding and/or milk expression session.
- demonstrating the use of recommended equipment.
- providing education and demonstration of techniques intended to aid breastfeeding/lactation.
- issuing referrals to other health care providers as needed.
- weighing my baby before and after feeding to assess milk transfer as needed.
- performing visual and physical assessments which pertain to breastfeeding/lactation assistance.

My Lactation Consultant is not responsible for changes to my situation that occur after consultation. It is my responsibility to communicate changes and new concerns to my Lactation Consultant as they arise.

My Lactation Consultant works within the scope of her IBCLC certification and ethics. It is my responsibility to discuss medical concerns and changes with my baby's primary care physician.

I give consent for my Lactation Consultant to contact my listed contact(s), as well as my baby's and my physician(s), with a report of our consultation, as the ethics of her profession require, and to consult with them in any way she deems necessary to our care. She may discuss my case with other Lactation Consultants and Practitioners as needed.

I give my consent for the Lactation Consultant to release necessary information to my insurance company and/or contracted billing agency as needed for payment.

I understand that total payment is expected at the end of the consultation and before my Consultant leaves my home. I will be given a superbill to submit to my insurance company for consideration of reimbursement if Harmony Lactation does not accept my insurance.

I consent the Lactation Consultant to use clinical information about my case to educate healthcare providers and other families as needed. I will not be identified in any way, but details of my situation will be discussed.

I understand that my address will be entered into GPS for the purpose of the Lactation Consultant to find my home for consultation, but will be used in no other way.

I acknowledge that text/SMS is not a form of protected communication, and that communication through my protected Patient Portal is recommended. I can also reach my Lactation Consultant by

phone.

I fully agree to this consent.

I understand that for this lactation consultation and all follow-up, the Lactation Consultant will protect the privacy of my personal health information (PHI) as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received a copy of, read and understand the HIPAA privacy policy.

Permission for Photography and Photo Use

☐ By checking the box to the left, I give my Consultant permission to photograph or video myself and my baby. Photography and video may be used to educate families and practitioners. My personal information will not be disclosed, but details about my situation may be shared for the purposes of teaching. Photography and video will not be used for advertising or marketing purposes.

Client

X _____

Print name: **Date:**