Lactation Consultation Consent Form

1. I hereby give my written consent for_____, to work with my baby (name) _____ and me during this and subsequent consultations for my breastfeeding problem/concern. I understand that this consultation may involve touching my breasts and/or nipples for the purposes of assessment, performing an oral digital examination on my baby in order to assess the suck, observation of a breastfeed, and demonstration of techniques and use of equipment that may be necessary to improve breastfeeding.

2. I give my written consent for_____ to send any and all pertinent information to my infant's and my primary health care providers, and to consult with them in any way she deems appropriate.

3. I give my written consent for_____ to release pertinent information to my insurance company as necessary.

4. I give my written consent for _____ to communicate with my health care professional and/or insurance company via mail, e-mail or fax.

5. I give my written consent to leave voice mail/text/e-mail messages. I understand that none of the above are encrypted. Verbal messages may also be left with anyone who answers the phone. (Restrictions as noted:
_____)

6. I give my written consent for _____ to use clinical information obtained during these sessions to be used for education of other health care providers about lactation.

7. I give permission to_____ to photograph me and/or my infant(s). I hereby acknowledge that these photographs/slides belong to her and that she may to use these to further the information available on breastfeeding management.

8. Additional Consent or Restrictions:
_____
_____

Mother's Signature_____

IBCLC's Signature_____

Date_____