Santa Barbara Lactation

CONSENT

- 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 visits, phone conversations, and information sent by e-mail, fax or text, 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 that I am responsible for informing the lactation consultant of changes I feel are necessary in the care path at the time of the visit or during the course of follow-up communications. Phone / e-mail / text contact during the time following the lactation visit is crucial and considered an extension of your visit. You 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 give my consent for 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 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 may be described and discussed.
- I understand total payment is expected at the conclusion of the consultation. I will receive an invoice 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 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 (HIPPA).
- I understand that a student lactation consultant may be present to observe my consultation.
- I have received a copy of this provider's Notice of Privacy Practices.

_____ _____

If Mother agrees (consents), signature here Date

Permission to use Photograph/Video

Date: _____

Mother:_____ Baby:_____

- I give permission for Jessica Barton, IBCLC to photograph or videotape myself and/or my infant(s).
- I acknowledge that these images belong to Santa Barbara Lactation and that the intended use of these images is for the purpose of education and the promotion of breastfeeding and lactation counseling.
- I permit these photographs/videos to be used for educational purposes, including exhibition at professional conferences and workshops; inclusion in an electronic educational presentation/CD/DVD; or publication in a scholarly medium.
- I understand that no specific names or identifying information will be publicly used.
- I understand that I will not receive further notification or compensation when these images are used.

I have read and understand the above:

Signature: _____

Email address: _____