WATCH ME GROW LACTATION SERVICES, LLC
RELEASE OF LIABILITY AND CONSENT/HIPAA

A lactation consultation, whether in person or virtual, usually includes visual and physical assessment of the breastfeeding parent's breasts, visual and physical assessment of the infant's mouth, observation of the breastfeeding parent and infant nursing, analysis of the data relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, and sometimes the use of breastfeeding equipment.

- I give permission for the Lactation Consultant to do all of the above.
- I understand that all medical care is to be provided only by a physician(s).
- I give my permission for information about this and all additional consultations to be sent to my attending physician(s)/healthcare provider(s).
- I understand the Lactation Consultant will make recommendations toward helping me reach my breastfeeding goals.
- I understand no outcome can be guaranteed. It is my responsibility to evaluate the effectiveness and sustainability of this care plan, and to contact my Lactation Consultant for advice, adjustments, and follow-up as necessary. Follow up consultations may be recommended, if needed. I understand that I have the right to refuse any or all specific techniques suggested or equipment to assist or remedy breastfeeding problems, and/or all recommendations.
- I acknowledge that the Lactation Consultant has provided their HIPAA policy and a HIPAA-compliant means of communication. If I choose not to use the HIPAA-compliant form of communication that the Lactation Consultant has provided, he Lactation Consultant will take all reasonable precautions to protect my privacy. I understand that email and text are not inherently secure means of communication.
- I understand that it is my choice to have someone else present during the visit and that anyone who sits in on the visit will have access to my healthcare information and my confidentiality may not be guaranteed. I acknowledge that the Lactation Consultant is not responsible for any breach of confidentiality made by anyone I invite to be present during a visit, or anyone added by me as a third party to text or email.
- I give my permission for information from this consultation/visit to be used to further the knowledge of breastfeeding and/or educational purposes.I understand that my identity and the identity of my child(ren) will be kept private. I understand that no specific names will be publicly used. I understand that this consultation is not being recorded, and that no pictures or videos will be taken or shared from this consultation without me providing prior written consent.
- I give my permission for information to be released to my insurance company to assist in the evaluation of a claim. I give my permission for the Lactation Consultant to bill my insurance and collect payment if I have not paid cash at the time of service. By submitting your name below, you agree to the terms provided above.

WATCH ME GROW LACTATION SERVICES, LLC
RELEASE OF LIABILITY AND CONSENT/HIPAA

Watch Me Grow Lactation Services, LLC (WMG) is committed to protecting the confidentiality of our patients' health information. The Privacy Policy describes how we may use and disclose your health information and your rights concerning your health information. This Notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA").

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WMG is committed to protecting the confidentiality of our patients' health information. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your health information and your rights concerning your health information. This Notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). The Lactation Network and its workforce members who are involved in providing and coordinating your health care are all bound by the terms of this Notice.

USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION

Except where prohibited by other laws that require special privacy protections, we may use and disclose your health information without your prior authorization as follows:

- We will use and disclose your health information to provide, coordinate and/or manage your treatment and any related services. We can use and disclose your health information with other providers involved in your care.
- Your health information will be used or disclosed, as needed, to obtain payment for the health care items and services we deliver to you.
- We may use or disclose your health information in order to carry out our general business activities or certain business activities of other involved providers. These activities include, but are not limited to, training and education; quality assessment/ improvement activities; risk management; claims management; legal consultation; physician and employee review activities; licensing; regulatory surveys; and other business planning activities. For example, we may use your health information to monitor the quality of the care we are providing to you.
- Unless you express an objection, we may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death.
- We may use or disclose your health information to the extent the use or disclosure is required by law. Any such use or disclosure will be made in compliance with the law and will be limited to what is required under the law.
- We may disclose your health information to a health oversight agency for activities such as audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.
- We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

YOUR HEALTH INFORMATION RIGHTS

- Inspect and/or obtain a copy of your health information. You have the right to inspect and/or obtain a copy of your health information maintained in a designated record set. You may obtain a copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your health information, you must submit a written request to WMG.
- Request a restriction on certain uses and disclosures of your health information. You have the right to ask us not to use or disclose any part of your health information for purposes of treatment, payment or healthcare operations. While we will consider your request, we are only required to agree to restrict a disclosure to your health plan for purposes of payment or healthcare operations (but not for treatment) if the information applies solely to a healthcare item or service for which we have been paid out of pocket in full. If we do agree to a restriction, we will not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment.

- Request confidential communications. You have the right to request that we communicate with you about your health information in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communication of your health information, you must submit a written request to WMG stating how or when you would like to be contacted. We will accommodate all reasonable requests. We will not require you to provide an explanation for your request.
- Request an amendment to your health information. If you believe that any information in your medical record is incorrect, or if you believe important information is missing, you may request that we correct the existing information or add the missing information. To request such an amendment, you must submit a written request to WMG.
- Request an accounting of certain disclosures. You have the right to receive an accounting of certain disclosures we have made of your health information. To request an accounting, you must submit a written request to WMG. The first accounting you request within a 12-month period will be provided free of charge. We may charge you for any additional requests in that same 12-month period.
- Obtain a paper copy of this Notice. You have the right to obtain a paper copy of this Notice upon request. To obtain a paper copy of this Notice, contact our WMG.

OUR RESPONSIBILITIES

- We are required to (i) maintain the privacy of your health information as required by law; (ii) provide you with notice of our legal duties and privacy practices with respect to your health information; (iii) abide by the terms of such notice; and (iv) notify you following a breach of your health information that is not secured in accordance with certain security standards.
- We reserve the right to change the terms of this Notice and to make the provisions of the new Notice effective for all health information that we maintain. If we change the terms of this Notice, the revised Notice will be made available upon request, posted to our website and posted at our delivery sites.
- We will not use or share your information if state law prohibits it. Many states have laws that are stricter than the federal privacy regulations we describe in this Notice. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. For instance, some states may provider greater protections for genetic testing information, HIV/AIDS information, mental health and developmental disabilities records, and alcohol or drug abuse records. The way that state and federal laws interact is complicated. If you would like to know more about applicable state laws, please contact WMG.

_____ (initials) I provide consent to the use of photography during my lactation consultation. Any photographs taken will become the property of Watch Me Grow Lactation Services and may be used for educational and publicity purposes. No identifying information (name, age, location) will be shared.

Breastfeeding Parent's Name (printed): _____

Breastfeeding Parent's Signature: _____ Date: _____

Lactation Consultant/IBCLC: _____ Date: _____