



CARING LACTATION

Kara Rambo, CPNP, IBCLC

Consent for Lactation Consultation

Thank you for scheduling an appointment with Caring Lactation for a lactation consultation with our International Board-Certified Lactation Consultant (IBCLC), Kara Rambo. During your visit, the IBCLC will review your health history, discuss your concerns, complete an assessment including visual inspection of your baby and your breasts, evaluation of your baby's mouth and suckling skills, answer your questions and develop a care plan with you. She will also provide you with information and resources based on your family's needs. Please review the following consents and initial each line.

_____ I authorize the IBCLC to hold my baby, evaluate my baby's suckling motions by touching baby's mouth, observe us feeding and/or pumping, view and touch my breasts and/or nipples for purposes of assessment, make suggestions for techniques, equipment and supplies to improve breastfeeding.

_____ I grant permission to the IBCLC to share pertinent information about this consultation with my/our family physicians and health care providers, the referring person, my/our community breastfeeding helper, my/our doula, my/our insurance companies and to further the knowledge of breastfeeding

_____ I understand the IBCLC will not diagnose or medically treat me or my child. Any change from my physician's recommendations should be discussed with my physician and that healthcare issues of a medical nature MUST be discussed with my physician.

_____ I understand that our success with breastfeeding is important to my IBCLC, but we are responsible for our own progress on a weekly basis based on the recommendations and suggestions offered by my IBCLC. I agree to hold harmless and indemnify Caring Lactation and my IBCLC for any outcome my baby or I may experience.

_____ 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).

_____ I acknowledge that my personal information will be held confidential by my IBCLC according to HIPPA guidelines. However, if I initiate or request electronic communications via text/email/messaging service, the platform I use may not be encrypted, secure and/or private, thus I grant my IBCLC permission to communicate with me by the method of my choice. If I decline to grant this permission, my IBCLC may only communicate with me by phone or mail.

Patient/Client or Person Authorized to Consent for Patient/Client

Date

IBCLC of Caring Lactation

Date