**Lactation with Theresa**

**Release of Liability & Consent for in-person and virtual lactation visits:**

 **(Please read and initial each section and then sign and date at the end of this document. Feel free to sign electronically or print, sign, and email a picture copy to me via e-mail)**

In a Lactation Consultation, in person visit, there is typically visualization of the breastfeeding mother’s breasts. There is also assessment of the infant’s mouth and tongue extension, as well as observation of the infant nursing. Even in a virtual lactation visit, there may be visualization of the breastfeeding mother’s breasts and infant’s mouth and breastfeeding. There is also analysis of the data related to the breastfeeding situation. Health information questions will be asked in order for the Lactation Consultant to gain an understanding of the breastfeeding situation. I give permission for the Lactation Consultant to do all 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 and my infant’s attending physician(s)/health care providers.\_\_\_\_\_\_\_\_\_

I understand that the Lactation Consultant will make recommendations toward helping me reach my breastfeeding goals. I understand that no outcome can be guaranteed. It is my responsibility to evaluate the effectiveness and sustainability of this care plan. I have the right to refuse any of the recommendations or techniques recommended.­\_\_\_\_\_\_\_\_\_

 It is my responsibility to reach out to my Lactation Consultant for advice, adjustments and any follow up as necessary. I understand that it may be necessary to request a follow up consultation. I understand that the Lactation Consultant may communicate with your and your infant’s physician(s)/health care providers.\_\_\_\_\_\_\_\_

I acknowledge that the Lactation Consultant is utilizing a HIPAA-compliant form of charting and communication. I understand that text and e-mail are not inherently secure means of communication, and the Lactation Consultant will take all reasonable precautions to protect my privacy.\_\_\_\_\_\_\_\_

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 will not be guaranteed.\_\_\_\_\_\_\_

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/children will be kept private and that no specific names would be used. I understand that no pictures or videos will be taken or shared from this consultation without me providing prior written consent.\_\_\_\_\_\_\_\_\_\_

In the case of a private pay lactation visit, I agree to pay via cash or Venmo at the conclusion of the visit.\_\_\_\_\_\_\_

I agree with the use of digital signatures in my interactions with the Lactation Consultant. Theresa is authorized to chart medical information into the TLN or Wildflower Company sites. Any signature of mine that is provided digitally will be assumed to carry all the weight and authority of an original manual signature. \_\_\_\_\_\_\_\_\_\_

I agree that I will not cancel/postpone more than 30 minutes, the appointment unless there is illness.\_\_\_\_\_\_\_\_\_

By submitting your name below, you agree to the terms provided above.

Mother’s name(print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

Lactation Consultant/IBCLC: Theresa R. Holland MSN, BS, IBCLC, ICCE­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_