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# Release, Consent & Contract for Breastfeeding Consultation/Support

## Consultation

I understand a breastfeeding consultation may include visual assessment of mother's breast and of the infant's mouth, observation of the mom and infant nursing, physical contact with both baby and breast for the purpose of offering suggestions and assistance, analysis of records related to the breastfeeding situation, demonstration of breastfeeding techniques, and may include the use of breastfeeding equipment.

I give permission to Jordan Sparks, Certified Breastfeeding Counselor (CBC), to perform all of the above for the purpose of providing breastfeeding support. This consent is for in-person visits, as well as phone conversations, and any information sent/communicated by e-mail, phone, fax, text messages, and/or private social media. I understand that electronic/cellular forms of communication may not be encrypted/secure.

## Follow-up

I understand that I am responsible for informing Jordan Sparks, CBC of any relevant information or changes that affect my breastfeeding situation, and that it is my responsibility to call with progress reports, questions, or concerns.

## Privacy

I understand that for this breastfeeding consultation and all follow-ups, Jordan Sparks, CBC will protect the privacy of my personal health information as required by Health Insurance Portability and Accountability Act of 1996 (HIPPA).

## Medical Advice

I understand that a breastfeeding consultation does not substitute for medical care, and that medical care can only be provided by a physician. Any advice given in the course of this consultation cannot replace medical advice received from a primary care provider. I understand that it is my responsibility to discuss any change in my care plan with my primary care provider.

## Refusal

I understand that I may, at any time, decline any and all specific techniques, breastfeeding equipment, and any and all recommendations provided.



## Payment

I understand that payment is due at the time services are rendered, and that obtaining reimbursement for breastfeeding consultations/support from my health insurance is my responsibility.

## Consent to Share Information

I give permission for the information collected (with the exception of my, and my infant's, names) to be used for educational purposes (i.e. to help train aspiring lactation consultants).

- Yes
- No

I give permission for the information collected (with the exception of my, and my infant's, names) to be shared with other perinatal professionals, for the purpose of peer review and/or collaboration.

- Yes
- No

I understand that this consultation is confidential, and that unsafe situations for parent or baby must be reported, as required by law.

- Yes
- No

## Messages

Please call (\_\_\_\_\_)\_\_\_\_\_. If unable to reach me,

- you may text.
- leave a detailed message.
- please leave a message asking me to return your call.

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Signature

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Date