Release of Liability and Consent Form

A lactation consultation, whether in person or virtual, usually includes visual and physical assessment of the breast/chestfeeding parent's breasts, visual and physical assessment of the infant's mouth, observation of the breastfeeding parent and infant nursing, analysis of the date relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, and sometimes the use of breastfeeding equipment. I give permission for Amy Owen, MA, IBCLC 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 send to my attending physician(s)/health care provider(s).

I understand the Lactation Consultant will make recommendations toward helping me reach my breast/chestfeeding 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.

I understand that my session includes 6 days of follow-up support with Amy Owen MA, IBCLC. After that time, for additional questions or requests for additional lactation support, I will need to request a follow-up consultation.

I acknowledge that Amy Owen provided their HIPAA policy and a HIPAA-compliant means of communication.

If I choose not to use the HIPAA-compliant form of communication that Amy Owen has provided, I understand that although email and text are not inherently secure means of communication 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 may not be guaranteed. I acknowledge that Amy Owen MA, IBCLC 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 third party to a 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 agree with the use of digital signatures in my interactions with Amy Owen MA, IBCLC.

Any signature of mine that is provided digitally will be assumed to carry all the weight and authority of an original manual signature.

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

_____
Lactating Parents Name (print)

_____ _____
Lactating Parents Name (signature) Date

_____ _____
Lactation Consultant /IBCLC Date