LITTLE LEAF LACTATION - POSTNATAL WELLNESS & LACTATION SUPPORT

# RELEASE OF INFORMATION

Date

Clients Name

First Name

Last Name

Clients Date Birth

DD/MM/YYYY

Infant/Childs Name (if applicable)

*In accordance with the Information Privacy Act 2009 (Qld)*

I, _____, consent to the release and/or collection of relevant personal and health information about myself and/or my infant/child _____, by Little Leaf Lactation, solely for the purpose of delivering appropriate postnatal care and/or lactation support services.

**This may include sharing or obtaining information such as**:

- Postnatal health assessments and recovery status
- Feeding plans, lactation assessments, and progress notes
- Medical or health history relevant to ongoing care
- Referrals, care coordination details, and professional recommendations

**Information may be shared with or obtained from the following parties, as relevant to care:**

- My general practitioner, midwife, obstetrician, or other health professionals
- My infant/child's pediatrician or other child health providers
- Hospitals, maternity units, child health services, or community health organisations
- Allied health providers involved in our care

This consent remains valid until (please tick one):

☐ The completion of care

☐ 12 months from the date below

☐ Other (please specify): _____

Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Provider Name: *Penny Estillore* RN RM IBCLC