



Mothers'
Milk Bank
of the Western
Great Lakes

1691 Elmhurst Road
Elk Grove Village, IL 60007
P: 847-262-5134 • F: 847-262-5983
Email: donors@milkbankwgl.org
Website: www.milkbankwgl.org

Dear Mother,

Please accept our deepest sympathy for the loss of your baby. We respect that this is a sad time for you and your family. You may have stored breast milk at home or in the hospital-- or you may be thinking about starting or continuing to pump. Some mothers take comfort in donating their baby's milk to a milk bank. If you choose to donate your milk, we will help you through this process. There is no minimum donation amount and we will always accept your baby's milk, even if you take medications. Please know that we will respect and honor any decision you make about milk donation.

If you wish to participate in "Poppy's Dream," we will honor your baby's milk donation by placing their name on a Special Star. Your baby's Star will join other Stars in our beautiful night sky in the milk bank lobby.

Please call or email us anytime if you have questions about milk donation. We appreciate the love and dedication that you put into pumping milk for your baby.

Sincerely,

A handwritten signature in cursive script that reads "Summer Kelly".

Summer Kelly, Executive Director
summer@milkbankwgl.org
847-262-5134

A handwritten signature in cursive script that reads "Susan Urbanski".

Susan Urbanski, Program Coordinator
susan@milkbankwgl.org
847-262-5134



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Donor Intake Form

Donor Name _____ **Date of Birth** _____

Race _____ **Ethnicity** _____

Occupation _____

Address _____

City _____ **State** _____ **Zip** _____

Email _____

Primary Phone _____

Baby's Name _____ **Date of Birth** _____

Sex _____ **Gestational Age (Number of Weeks Pregnant at Birth)** _____

Baby's Name (Twin #2) _____ **Date of Birth** _____

Sex _____



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Donor Consent Form

1. I voluntarily choose to donate my milk to Mothers' Milk Bank of the Western Great Lakes (Milk Bank WGL). I understand that my participation is voluntary and I will not be paid for my donation. I understand that my milk will not be sold, but a processing fee will be charged to the recipient of the milk.

2. I understand that as a milk donor, I have the following responsibilities:

- Express and store my milk according to the instructions provided by Milk Bank WGL
- Get blood tested as described in the "Blood Test Information and HIV Test Consent" form
- Notify Milk Bank WGL if I, or a household member, becomes ill
- Notify Milk Bank WGL if I take any new medications, vitamins, herbs, or supplements
- Notify Milk Bank WGL if I am exposed to a contagious disease
- Contact Milk Bank WGL if I have any questions about being a milk donor

3. I understand that once I donate my milk, it becomes the property of Milk Bank WGL and cannot be returned due to potential liability. I understand that approval as a milk donor does not mean that my milk is safe to sell or share informally.

4. I understand that Milk Bank WGL may use my milk for the following purposes:

- Processing and distribution to infants and children in hospitals and the outpatient setting
- Distribution to critically or chronically ill adults after medical need has been established
- Milk Bank WGL quality control testing and/or machine calibration
- Distribution to other non-profit milk banks during critical shortages
- Research (see # 5)

5. I understand that Milk Bank WGL may use my milk for internal or external research projects. If my milk is used for external research projects, all identifying information will be removed prior to use (milk will be provided to the researcher in a new bottle or test tube that does not contain my name, donor number, or any other identifying information).

6. I understand that I am encouraged to discontinue donating milk at any time if donation interferes with my baby's, family's, or personal needs.

I hereby certify to the best of my knowledge that I understand and consent to milk donation.

Signature

Date

Printed Name



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Poppy's Dream Memorial Release

“Poppy’s Dream” is a memorial in our milk bank lobby that honors special milk donations, like the donation that you are making in your baby’s honor. If you agree to participate, we will place your baby’s name and birthdate on a unique star that will join other stars in our beautiful night sky. If you would like to participate in Poppy’s Dream, please complete this form.

The undersigned hereby transfers and grants to Mothers’ Milk Bank of the Western Great Lakes (Milk Bank WGL) the exclusive right to create and display a plaque as part of “Poppy’s Dream” the baby’s name and birth date for:

Baby’s full name: _____ Date of birth: _____

Please write your baby’s name as you would like it to appear on their Special Star. Only their first name, middle name, and/or nickname will be used. _____

The undersigned also hereby transfers and grants to Milk Bank WGL the exclusive right to use and authorize others to use all or any part of my (his/her) interview/photograph/video in related media such as books, magazines, journals, pamphlets, electronic (Internet) and other written and video formats of the “Poppy’s Dream.” The undersigned also hereby releases Milk Bank WGL and its directors, members, trustees, officers, employees, and agents from any and all claims, demands, causes of action and suits, including but not limited to, claims for invasion of privacy, defamation, breach of contract or other breach of duty arising out of or in connection with the use of this interview, photograph, or video of the “Poppy’s Dream.”

Mother’s Signature

Date

Mother’s Printed Name



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Acknowledgement of Receipt of Privacy Notice

By signing this form, you acknowledge that you received a copy of the Notice of Privacy Practices from Mothers' Milk Bank of the Western Great Lakes. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.milkbankwgl.org or by request from our staff.

Please list any privacy preferences or choices (optional):

I acknowledge receipt of the Notice of Privacy Practices from Mothers' Milk Bank of the Western Great Lakes.

Signature

Date

Printed Name

Your Rights**Get an electronic or paper copy of your donor record**

- You can ask to see or get an electronic or paper copy of your donor or outpatient record and other health information we have about you or your child.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your donor record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Officer, Summer Kelly, at 1691 Elmhurst Road, Elk Grove Village, IL 60007; 847-262-5134; summer@milkbankwgl.org
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

Our Uses and Disclosures**How do we typically use or share your health information?**

- **Run our organization** - We can use and share your health information to run our organization and contact you when necessary. We may share information with your healthcare provider, your baby's healthcare provider, your hospital or clinic staff, your local milk depot, the blood-testing laboratory, or others. For example:
 - We notify your primary healthcare provider (PCP) and your baby's PCP that you intend to donate milk

- We may send your blood test results to your PCP
- We may be asked to verify your identity, by providing your date-of-birth (or other identifier), when we communicate with staff at your PCP's office, your hospital, or the laboratory
- If you drop your milk off at a milk depot, you will be asked to provide your name and donor number to the milk depot volunteers
- If your milk is stored in the hospital freezer, we may contact the hospital nursing or lactation staff
- **Bill for services (receiving donor milk)** - We can use and share your health information to bill and get payment from health plans or other entities.
 - We provide information to your insurance company if they contact us about a donor milk claim
 - We may submit a claim or request for reimbursement for donor milk dispensed to your child
- **Education and marketing** - We may contact you via mail, email, or telephone to update you about:
 - Our growth, progress, and fulfillment of our mission
 - Community events like our annual Race to Save Tiny Lives
 - Fundraising events like our end-of-year giving campaign
 - **You may opt out of our newsletter/marketing list at any time**
 - **We DO NOT sell or share your information to any third party companies or organizations for marketing or fundraising purposes**

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
- Help with public health and safety issues - We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
- Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Address law enforcement and other government requests - We can use or share health information about you:
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
- Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.