Connecticut Department of Public Health
Family Health Section

Newborn Hearing Screening
Refusal Waiver

As defined in Section 19a-59 of the Connecticut General Statutes, I the parent or guardian of _____(newborn name), a baby born on _____(date of birth), in _____ (birthing facility/hospital name), refuse permission for the Newborn Hearing Screening Test to be performed on my baby, because such a test is in conflict with my religious tenets and practice. The risks and benefits of the Newborn Hearing Screening have been fully explained to me and I understand and accept responsibility for choosing not to have the screening performed.

Accession Number: _____

Birth Mother's Name (Please print):_____

Street Address:_____

Town/Zip Code:_____

Infant's Primary Care Physician:_____

Physician's Address:_____

Physician's Telephone:_____

Parent/Guardian Signature: _____

Relationship (if other than parent):_____

Witness:_____

Date:_____

A copy of this signed waiver is to be forwarded to:
Connecticut Department of Public Health
Early Hearing Detection & Intervention Program
410 Capitol Avenue, MS #11 MAT
Hartford, Connecticut 06134-0308
FAX: 860 509-8132