NEWBORN HEARING SCREENING REFUSAL

I, _____, ask that the newborn hearing screening **NOT**
(Parent or Legal Guardian Name)

be performed on my baby _____.
(Baby's Name)

I release _____, my physician/health care provider
(Birthing Facility Name)
from any fault for disability or injury to my baby that might have been found by hearing screening. I have read the newborn hearing screening information. I fully understand what I read. I am responsible for choosing not to have the screening done.

_____
Print Name of Parent or Legal Guardian

_____
Signature of Parent or Legal Guardian

_____
Date

_____
Signature of Witness (Optional)

_____
Date