Connecticut Department of Public Health

Family Health Section
Early Hearing Detection & Intervention Program
410 Capitol Avenue, MS #11 MAT
Hartford, Connecticut 06134-0308

Newborn Hearing Screening Refusal Waiver

As defined in Section 19a-59 of the Connecticut General Statutes, I, _____ (the responsible party), of _____(infant's name), a baby born on _____(date of birth), in _____ (birthing facility/hospital), 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: _____

Parent/Responsible Party Name (Please print):_____

Relationship (if other than parent):_____

Street Address:_____

Town/State/Zip Code:_____

Infant's Primary Care Physician:_____

Physician's Address:_____

Physician's Telephone:_____

Parent/Guardian Signature: _____

Witness:_____

Date:_____

To be filed with the Hospital/Birthing Facility Medical Record of this infant
Send a copy of this signed waiver to:
Connecticut Department of Public Health
Early Hearing Detection & Intervention Program
410 Capitol Avenue, MS #11 MAT
Hartford, Connecticut 06134-0308

PHONE: 860-509-8251 FAX: 860-629-6965