

NEWBORN HEARING SCREENING FORM

I, _____, request that the newborn hearing screening not be
(Parent or Legal Guardian Name)
performed on my baby prior to discharge from _____.
(Birthing Facility Name)

I release _____ and my physician/health care provider
(Birthing Facility Name)
from any liability for disability or injury to my baby that might have been detected by hearing
screening. I have read and fully understand the informational brochure on newborn hearing
screening, and accept the responsibility for choosing not to have this screening performed.

Print Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date