REGISTERING YOUR NEW COCHLEAR DEVICE IS IMPORTANT

Registration ensures your product is covered under the Cochlear Global Limited Warranty and enables prompt support to be provided directly by Cochlear or your hearing health professional when needed.

1. Please complete this form with all required details. If you're unsure where to find any of the details requested on the form, ask your hearing health professional or contact your local Cochlear office.
2. Sign and date the form.
3. Return the form to your local Cochlear office (details on the back of this form)

*Required fields

FOR NUCLEUS IMPLANTS ONLY

Place sticker from implant box here OR fill in number manually (if known)

Serial number* *Place sticker with serial number (provided with the device) here OR fill in number manually*		Product model *Example: Nucleus® CP910 or Baha® 5*	Activation date* *Example: FEB/26/2016*	Which side?* *(please tick correct box)*	
Sound Processor	*Actuator unit serial number (for Baha 5 SuperPower only)*			L	R
Sound Processor	*Actuator unit serial number (for Baha 5 SuperPower only)*			L	R
Remote Assistant					
Remote Assistant					
Hybrid Acoustic Component	*Recipient ID number* (for Hybrid™ Acoustic component only)*			L	R
Hybrid Acoustic Component	*Recipient ID number* (for Hybrid™ Acoustic component only)*			L	R

Recipient details

Last name* **First name***

Gender* ◯ Male ◯ Female **Date of birth*** Month Day Year *Example : 15-01-1999*

Address Number Street

City* State Zip

Phone - - **Mobile** - -

E-mail address

Parent or guardian details *(If the recipient has not reached the age of majority)*

Last name*

First name*

Contact details are the same as for the child* ◯ Yes ◯ No *(please fill in details below)*

Phone - -

Mobile - -

E-mail address

Audiology Centre

Organization

Town / City

Country

Audiologist Title Surname Given names

COCHLEAR AMERICAS
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(To be completed by U.S. residents only)

93816

By my signature below, I authorize Cochlear to use and disclose my protected health information (my name and the fact that I use a Cochlear Device), to communicate to me important marketing and related information about my Device. Cochlear's ability to use my information is limited as explained below.

Protected Health Information
This authorization relates to my name, contact information, and information pertaining to or related to my hearing condition and use of Cochlear-branded implantable hearing solutions ("protected health information") created or obtained by Cochlear Americas.

Use and Disclosure of Protected Health Information
Cochlear Americas may use or disclose my protected health information as explained in this authorization form. I agree that references in this authorization to Cochlear Americas include the employees, agents and contractors of Cochlear Americas. I agree that Cochlear Americas may use my protected health information to provide me with marketing related information about Cochlear Americas and its products and services, and/or information about clinics or hospitals that could provide me with further evaluation or treatment alternatives. This information may be mailed or emailed to me or may be provided by invitation to various seminars or by requesting my participation in various surveys. I will always have the right to "opt out" of receiving future communications.

The use or disclosure of my protected health information for these marketing purposes will not result in any direct payment to Cochlear Americas by any third parties. If I decide to receive additional treatment based upon the information provided to me as a result of this authorization, I understand that Cochlear Americas may receive payment related to the products used for that treatment.

Duration of Authorization/Right to Revoke Authorization
This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke or amend this authorization at any time but that I may only do so by sending my written notification of revocation to the Privacy Officer at Cochlear Americas, 10350 Park Meadows Dr STE 100, Lone Tree, CO 80124-9911. I understand that a revocation is not effective to the extent that Cochlear Americas, or its employees, agents, and/or contractors have already relied upon my authorization for the use or disclosure of my protected health information.

I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

My Rights
I understand that I have the right to (1) inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and (2) refuse to sign this authorization. Cochlear Americas and its employees, agents, and/or contractors may NOT condition any treatment I might elect to receive from others on whether I provide authorization for the requested use or disclosure.

By my signature below, I acknowledge that I have been provided the information to be able to view Cochlear Americas' Notice of Privacy Practice (U.S.), which is located at http://www.cochlearamericas.com/noticeofprivacypractices/ or is available by calling 1-800-523-5798 to request a copy to be mailed to me.

Cochlear periodically conducts market research through surveys to improve services and products. If you wish to be invited to voluntarily participate in surveys we require your permission to do so.

☐ I agree to be contacted by Cochlear to participate in market research surveys.
☐ I do not agree to be contacted by Cochlear to participate in market research surveys.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Description of Personal Representative's Authority

Return the form to Cochlear:

Cochlear Americas
10350 Park Meadows Dr STE 100, Lone Tree, CO 80124-9911, USA
Tel: 1 303 790 9010 Fax: 1 830 205 9189

www.cochlear.com

610105-3
306537 V5 2025-07

English

Cochlear™

Device registration form

For U.S. residents only

Hear now. And always

Cochlear®