[Name of Hospital]

[Street]
[City], MA [Zip]
TEL: FAX:

USE OF ELECTRONIC DEVICE AGREEMENT

Pt.Name: ID#:

The Department of Mental Health (DMH) policy "Electronic Device Use" (#12-01) has been reviewed with me. I ____ agree to follow the policy regarding the use of an Electronic Device.

In addition to the restrictions identified in the policy, I will respect the privacy of all Patients, staff and visitors at [Name of Hospital] by refraining from photographing any individuals or any aspect of the hospital surroundings during my stay. I will not upload any visual, audio, or text information regarding Patients, staff and visitors at [Name of Hospital] to any personal or social network internet web sites (example: My Space , Face Book, Twitter, etc.)

My Electronic Device will be turned off and not used during all treatment or evaluation activities while I am participating in such treatment or activities. My Electronic Device will be password protected when not in use. I acknowledge that I am responsible for my own property.

I will also respect the privacy of all Patients, staff and visitors at [Name of Hospital] by refraining from making video or audio recordings of any individuals during my stay and will also refrain from allowing access to confidential unit communication.

I understand that I will be required to relinquish my Electronic Device for failure to abide by the above conditions. The Electronic Device(s) in my possession are the following:

Make/Brand	Internet Wi-Fi Capability Y/N	Model No.	Serial #	Color	Phone #.(if applicable)

I understand I am responsible for all costs incurred for all phone/computer Wi-Fi charges or replacement or repair.

[Name of Hospital] is not responsible for lost or stolen items.

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The original is placed in patient's record.

Patient's Signature: ____ Date: ____________

Treatment Team Member Signature: __________________________________ Date: ____________

Treatment Team Member Signature: __________________________________ Date: ____________

Treatment Team Member Signature: __________________________________ Date: ____________

Treatment Team Member Signature: __________________________________ Date: ____________

Treatment Team Member Signature: __________________________________ Date: ____________

Treatment Team Member Signature: __________________________________ Date: ____________