[Name of Hospital] Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [Street] ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [City], MA [Zip]

 Tel: [###-###-####] Fax:[###-###-####]

**Massachusetts Department of Mental Health**

**Use of Personally–Owned Electronic Device Agreement**

The intention of this use of personally-owned electronic device (“Device(s)”) agreement is to establish ground rules to assure privacy and safety for all and to support people’s health and well-being.

PRIVACY AND SECURITY:

* I will respect the privacy of all Massachusetts Department of Mental Health (“DMH”) patients, clients, staff and visitors.
* I will not livestream, photograph, video or audio record any individuals or any aspect of the hospital/program surroundings.
* I will not create or share any livestream, video, photograph, audio, or text information regarding DMH patients, clients, staff or visitors (e.g., in email or to any social media network(s) or internet web sites, such as Instagram, Facebook, Snapchat, Twitter, etc.).
* I will only use the camera/webcam for purposes approved by my treatment team, such as telehealth interactions, personal interactions with family or friends or for an approved accommodation for a disability as a privacy protection; however, I will keep the camera/webcam off for confidentiality reasons if I am not in a private setting and there are other people around.
* I understand that when I use the camera/webcam to participate in interactions with people outside the hospital/program, information may be revealed that identifies the hospital/program I am in.
* I will turn off the Device during all treatment or evaluation activities while I am participating in such treatment or activities or groups, unless I am using the Device for permitted telehealth or treatment purposes or an approved accommodation for a disability.
* I understand that [Name of Hospital] (the “Hospital”) is not responsible for other people’s use of their electronic devices. If I believe someone, such as staff or another patient/client, has used a Device in violation of this agreement, such as by recording me or taking my picture, I can report it immediately to staff.

LIMITS AROUND USE AND POSSESSION

* I will do my best to be considerate of other patients, clients, staff or visitors who may be disturbed by my use of the Device.
* I will not connect, dock or otherwise synchronize the Device to any smartphone, computer, laptop, server, or other device, system or network that is not owned personally by me.
* I will not use Devices for any illegal purpose, such as the violation of a restraining order or for illegal internet usage or in violation of any the Hospital/DMH protocols or policies.
* I acknowledge that I am responsible for my own property and I understand that the Hospital is not responsible to replace my Device or any accessories (such as charging units, headsets, etc.) if it is lost, stolen or damaged.
* I will report to staff a lost or stolen Device or accessory immediately upon discovery that the Device or accessory is missing.
* I understand that the Hospital is not responsible for any mobile carrier charges associated with personal, telehealth, or other uses of my Device.
* I agree that while I am at the Hospital I will not allow any other person (patient or staff) to use my Device, except to demonstrate compliance with this agreement.
* I will keep my Device locked and password protected when not in use and will not share my password with any peers.
* I agree to follow all the rules around how I can use my Device safely and respectfully established by the Hospital and/or my treatment team.

MONITORING OF ELECTRONIC DEVICE USE

* I understand that if I fail to comply with the restrictions and limitations on the use of my Devices I may not be permitted to possess or use such Devices while I am at the Hospital.
* I understand that if my treatment team believes I have violated this agreement; my Device will be taken from me and subject to inspection. I will unlock my Device or provide the password to my Device to Hospital staff to provide access for inspection. I understand that if I refuse to provide access, I will lose possession and use of the Device, at least, until I provide access for inspection.
* Depending on the nature of the misuse of the Device, I may be able to regain use of the Device by working with my treatment team and addressing the problem.

I understand that I will not be able to use my personally-owned electronic devices if I do not follow this agreement. I authorize the Hospital to inspect my Devices in accordance with this agreement and the Hospital’s policies, protocols, and procedures.

The Device(s) I have access to are the following:

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

If I receive any replacement or additional Devices subsequent to my signing this agreement, I will notify a member of my treatment team and sign a new agreement that lists all replacement or additional Devices.

I understand and agree to follow the terms and conditions regarding the use of my personal electronic devices set forth in this agreement.

Patient/Client Signature: Date:

Staff Witness: Date:

Instructions:

1. Provide a copy of this agreement to the patient/client and, if applicable, the Legally Authorized Representative.
2. Place the original in patient’s/client’s record.