



Maxine Moncrieffe, D.D.S., P.A.  
Cosmetic & Restorative Dentistry

**CONSENT TO THE USE OF PHOTOGRAPHS AND/OR VOICE**

I, the undersigned, residing at;

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

I do hereby give my written consent to the office of Dr. Maxine Moncrieffe, DDS, PA. at 10843 Dylan Loren Circle, Orlando, FL. 32825, its successors, assigns and licensees and any agencies designated by Dr. Moncrieffe, to use my photographs and/or voice for slide or film/video tape purposes including the use of said photographs on television, in magazines and newspapers/print advertisement and the internet (world wide web), wherever, whenever and in whatever manner they shall desire, consistent with good taste which will not be derogatory, degrading or detrimental to me in any way.

I understand that the use of my medical records may result in disclosure of my "individually identifiable health information" as defined by the health Insurance Portability and Accountability Act("HIPPA"). I hereby consent to the disclosures(s) as set forth above. I will not, nor shall anyone on my behalf seek, legal equitable or monetary damages or remedies for such disclosure.

I acknowledge that use of my medical Records is without compensation and that I will not nor shall anyone on my behalf have any right of approval, claim of compensation, or seek or obtain legal, equitable or monetary damages or remedies arising out of any use that comply with the terms of this Consent.

A photostatic copy of this Consent shall be considered as effective and valid as the original. I have read, understand and agree to the terms set forth in this consent as indicated by my signature below.

My hand and seal this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

(Sign Here) \_\_\_\_\_

(Print Here) \_\_\_\_\_

Witness \_\_\_\_\_