

**Bayside Medical Mission and La Vida Clinic and Surgical Center**  
**Photo and Other Digital Media Consent and Release Form**

By signing this form, I hereby grant Bayside Medical Missions and La Vida Clinic and Surgery Center the use of photos or videos taken of me during my Mission Trip in Ecuador.

Trip Dates: \_\_\_\_\_

These may be used in publications, news releases, online in social media and websites, and in other communications related to the mission of Bayside Medical Missions and La Vida Clinic and Surgical Center.

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Signature: \_\_\_\_\_

(Signed by person or authorized person if signing for person 18 years or younger)

Date: \_\_\_\_\_

Name \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

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

**Thank you!**