

## **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 any Mission Trip in which I participate.

These may be used in publications, news releases, online, social media and websites, and other communications-related missions of Bayside Medical Missions and/or La Vida Clinic and Surgery Center.

Printed name of participant \_\_\_\_\_

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

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

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

Signature of participant: \_\_\_\_\_

If the person signing above is younger than 18 years of age, the legal guardian must sign below:

Printed name of guardian: \_\_\_\_\_

Signature of guardian: \_\_\_\_\_

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

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

**Thank you!**