

First Choice Medical Care, PLLC
1950 Cook St. Suite C & D
Dyersburg, TN 38024

PATIENT NAME: _____
DOCTOR'S NAME: _____ DATE: _____

_____ I give First Choice Medical Care Permission to leave results of tests and medical treatments on my:

_____ I give First Choice Medical Care permission to leave instructions regarding my appointment on my:

_____ answering machine

_____ voicemail

_____ with the following people:

Name: _____

Address: _____

Name: _____

Address: _____

_____ **I DO NOT give First Choice Medical Care permission to leave results with any other person other than myself, nor on any answering machine or voicemail.**

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

POWER OF ATTORNEY
&
LIVING WILL

I have received a copy of the information regarding Power of Attorney and Living Will. I do not have a Power of Attorney and Living Will on file. If I decide to use it, I will provide a copy.

Patients Signature: _____ Date: _____

Witness Signature: _____ Date: _____