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: _____________________