# Choices: Make Them Yours Make Them Known

FirstHealth OF THE CAROLINAS

# Advance Directives
## Health Care Power of Attorney & Living Will

To: FirstHealth of the Carolinas, Release of Information

From: ______________________________

Date: ______________________________

Total Pages (including cover): __________

*Please add my Advance Directives to my medical record. If a medical record does not exist, please create one for me. I have shared copies of my Advance Directives with my physicians, family, minister, and friends.*

Printed Name: ______________________________
(Last) (First) (Middle)

Date of Birth: ______________________________
(Month/Day/Year)

Current Address: ______________________________

______________________________

Current Phone Number: (          ) ______________________________

Last 4 digits of Social Security Number: __________

Health Care Power of Attorney attached (check one): ☐ Yes ☐ No

Living Will attached (check one): ☐ Yes ☐ No

Other: ______________________________

Attached documents are (check one): ☐ New ☐ Replacements to documents on file at FirstHealth

Mail to FirstHealth, Release of Information , P.O. Box 3000, Pinehurst, NC 28374 or fax to FirstHealth at 910-715-5456