Hayne D. McMeekin, MD
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Confidentiality Release of Medical Information Form

I____

Authorize Hayne McMeekin MD to :

- ○ Release Information regarding my medical information to ____________________
____

- ○ Obtain Information regarding my medical information from __________________
____

- ○ To discuss all information concerning my medical care with the following: ______
____
____
____
____

This authorization is valid from ___________ to __________ and is strictly for the purpose indicated above.

Signature_____________________________________Date_____________________

- ○ 1700 First Baxter Crossing, Suite 203, Fort Mill, SC 29708

- ○ 1590-1 Constitution Blvd., Rock Hill, SC 29732