DRS. AKERS, STOHLE & BORDEN, LTD.
ORAL AND MAXILLOFACIAL SURGERY

I, ____, hereby acknowledge that I have received a copy of Drs. Akers, Stohle & Borden, LTD's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

I have listed below the people who have permission to access my financial and/or medical information regarding my treatment with Drs. Akers, Stohle & Borden, LTD.

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Signature Date