COLLEGE OF LIBERAL ARTS

TAMU Psychology Clinic

Department of Psychological & Brain Sciences

Future Record Request Verification Form

Please provide all information thoroughly. This information will be used to verify your identity if you request Clinic records in the future. Client identity information is stored securely and protected from disclosure in accordance with Federal and State laws.

For office use: Client Record Number

Client's Full Legal Name:_____
Last First Middle Suffix

Address:_____ Last 4 digits SSN_____

City:_____ State:_____ Zip Code:_____

Home Phone #:(_____)_____ Work Phone #:(_____)_____

Mobile Phone #:(_____)_____

Sex/Gender:_____ Age:_____ years Date of Birth:_____/_____/_____
month / day /19xx or 20xx

Ethnicity: Anglo/Caucasian African American Asian/Pacific Islander American
circle/write
Hispanic/Latino-Latina Native American Other:_____
(please describe)

Parent or Guardian's Full Legal Name (if Applicable):

_____
Last First Middle Suffix

_____
Last First Middle Suffix

Client's Signature:_____ Date:_____

Parent's/Guardian's Signature:_____ Date:_____
(if Applicable)

Parent's/Guardian's Signature:_____ Date:_____
(if Applicable)

Therapist/Evaluator's Signature:_____ Date:_____

Faculty Supervisor's Signature:_____ Date:_____

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Physical Address
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