

## EXHIBIT B

### CONSENT FOR STUDENT TO SUBMIT TO DRUG AND/OR ALCOHOL TESTING AUTHORIZATION FOR RELEASE OF TEST RESULTS, AND RELEASE OF LIABILITY

I, \_\_\_\_\_, have been informed that CommonSpirit Health, or the parent, affiliated or related hospital facilities (collectively “CSH” or “Hospital”), its employees or agents and/or my educational sponsoring institution, or the parent, affiliated or related facilities (collectively “Sponsoring Institution”), its employees, or agents, is requesting that I submit to drug and/or alcohol testing to detect the presence of drugs or alcohol for the following reason: (check one)

\_\_\_\_\_ Post-offer/Pre-placement in clinical experiences/program (“Program”) at CSH or Hospital. \_\_\_\_\_ Reasonable Suspicion/For Cause

I understand that the testing for drugs will be done by at least a 10-Panel drug screen. I further give my permission for CSH and/or Sponsoring Institution to test for drugs at a higher level panel drug screen if it chooses. If required by state law, I have received a list of substances for which I will be tested. I have been informed and I understand that my agreement to submit to the requested drug and/or alcohol test(s) is completely voluntary on my part, and that I have the right to refuse to submit to the test(s). I am aware and have been told that I may be required to produce documentation to verify information contained in this consent and that my refusal to submit to the drug and/or alcohol testing or failure to cooperate in any way will be grounds for refusal to allow me to participate in the Program.

I understand and consent to the release of the results of my drug and/or alcohol test(s) to CSH’s Human Resource Department, Hospital Human Resources Manager and the Sponsoring Institution, as applicable, or their designees, as may be necessary. I understand that test results will be used to determine if I qualify to participate in the Program or have violated CSH’s or Hospital’s rules concerning drug/alcohol use and will be grounds for refusal to allow me to participate in the Program. I understand this information will be kept confidential and disclosed as permitted by law or as necessary per CSH, Hospital and/or Sponsoring Institution policies.

I acknowledge and agree that the sample given by me shall become the property of CSH, the Hospital and/or Sponsoring Institution and I hereby relinquish all rights to ownership and possession thereof. Fees for the initial test will be paid for by the Sponsoring Institution or me. Individuals that undergo post-offer/pre placement testing do not have the right to request an independent lab to complete an additional analysis from the initial split sample. Following and offer of placement, other types of testing may allow a re-test and if applicable, I must request this additional test within seven (7) business days from the receipt of notification of the original test result by written request to CSH Human Resources, Hospital or the Sponsoring Institution, as applicable. I will be responsible to pay for the additional analysis requested, unless the test result is negative.

Re-disclosure: I understand that the information used and/or disclosed by this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality

Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire once stated purpose above is served.

Revocation: I understand that I may revoke the authorization to disclose results (but not my consent to be tested following provision of the sample) at any time prior to disclosure by written notice to CSH or Sponsoring Institution, as applicable at **[Insert Address]** and directed to **[Insert Department]**.

This Authorization is binding: The statements made in this authorization are binding, controlling, and I understand that they take precedence over statements made in CSH's, Hospital's or Sponsoring Institution's Notice of Privacy Practices.

I agree to **HOLD HARMLESS, RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE CSH**, nor its parent, affiliates, officers, trustees, directors, contractors, providers, agents, employees, related facilities, and physicians, and/or Sponsoring Institution from any and all liability, claims, demands for injury, or other causes of action I have now or may have in the future which may arise from CSH, Hospital and/or Sponsoring Institution, or their designees requesting, performing, disclosing, and using the results of these tests.

I hereby represent that I have read and understand the above information and have voluntarily agreed to submit to the requested drug and/or alcohol test by urinalysis, blood and/or other testing requested by the Institution at the laboratory designated, and in recognition of my agreement, sign below.

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Student Signature

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Date